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Title	**Factors which influence understanding and adherence to hospital discharge instructions: a qualitative study**
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Reviewer 1	Emily Mulligan
Institution	Winchester District Memorial Hospital, Research
General comments (author response in bold)	- Excellent paper. I think you really highlighted what gaps you are addressing and what you are adding to the field. It was well written, easy to follow, and had great flow. You can tell your thoughts and ideas were well planned out and organized. - I don't have any suggestions for modifications. **We thank the reviewer for these comments and hope you agree our paper has been strengthened further by our revisions.**
Reviewer 2	Christopher Fermandes
Institution	Hamilton Health Sciences/McMaster University, Emergency Medicine
General comments (author response in bold)	This qualitative study attempted to show the factors impacting understanding and adherence to discharge instructions. The authors identify such factors as part of a necessary patient-centred framework. Introduction--p4, line 40--unclear whose knowledge gap you have identified **We have removed this term "knowledge gap" from our introduction on page 3 and have clarified the objectives.** -Methods--p5, line 15--in your introduction, you focus on chronic disease, yet you include pneumonia in your selection of participants. It is also unclear why only these 3 specific diagnoses were chosen. **We have removed the term "chronic disease" and have clarified why we focused on these 3 quality-based procedures in the introduction on page 1 and methods on page 4.** -p5, lines 24-31--This is a very small cohort from which to identify themes. The number of participants for whom themes were identified was based on the saturation of themes rather than a fixed number of participants or sample size. Limitations of qualitative study design have been highlighted on page 12. -p6, line 22-you have mentioned interrater reliability--what was the result? **We have clarified that interrater reliability was not measured but used as part of the qualitative data analysis on page 5.** -Results--p7, line 50--a large number of patients across the province, and across the country, do not have a PCP. How does this impact the generalizability of your study? **We thank the reviewer for this comment and have added this to our limitations on page 12.** -p8, lines 36-38--this is a significant result. Many previous studies have identified the poor translation provided by family members as impacting patient care. **We agree this is a significant result which is now highlighted in our discussion on page 11.**

	-References--A number of references were not immediately relevant to this study, and/or dated. I would suggest a significant reduction in the references listed. **We have removed references 7, 8, 21, 23, 26, 33 and 34 and updated others (added new reference 29 and updated reference 10) to ensure they are more up to date to the date of resubmission or in reference to suggestions from reviewers (added COREQ reference).**
Reviewer 3	Braden Manns
Institution	University of Calgary, Medicine and Community Health Sciences
General comments (author response in bold)	This was a qualitative study that assessed patient and family caregiver perspectives on factors which impact understanding and adherence to discharge instructions. I was pretty surprised to see how poorly they rated their knowledge after discharge (Table 1)! So the study presents interesting findings and a new pneumonic! (READ). The themes they identify make sense, and it will be very interesting to know whether the intervention in the RCT (which needs more description herein…) is effective at modifying outcomes (whatever those are in the RCT) and whether it changed patient's experience. This is "mentioned" in the interpretation section, but a bit more data on the impact that the "rest of the intervention" might have had on patient's perceptions would have been helpful. While the interviewers might have been blinded, surely you know which patients were in the intervention arm? **We have clarified in the methods on page 4 that we remained blinded to the study intervention of our participants which was delivered by the health-care team and not the research team. We have furthermore added to the limitations on page 12 how the intervention may have impacted the qualitative themes identified.** -This paper should be required reading for ward nurses, and residents / hospital physicians. Of note, I suspect that many of the barriers would not simply be overcome by discharge instructions on their own – which the authors acknowledge in their conclusion. And indeed, many of the patient's experience seem to relate to time pressures that hospital staff face – which isn't going to change (but why do we have to wait to the last day to start the teaching?). You may want to create an infographic out of your "READ" pneumonic and use it as a teaching tool for hospital staff. **We thank the reviewer for this excellent suggestion for further knowledge translation of our work.** -I have a few suggestions: A bit more detail on the sample (in comparison to the overall types of patients in the study) would be helpful. Was this a representative sample? How do the patient compare to the other participants? **We have clarified in the methods that the objectives of the qualitative study and RCT differ, as do their "samples" on page 4. We have added the overall number number of participants who consented to the qualitative study from the total number who were enrolled in the RCT at the time of data saturation with themes on page 6.** -Also, you never say why you chose 27? This is a reasonable size for a qualitative study… but did you reach saturation of themes? Or was there another reason you stopped? **We have clarified on page 5 that enrollment ended when data saturation was met and no further themes were found.** -Were some of the caregivers related to the patients? (or were these "separate observations" – so to speak?) **We have clarified that all caregivers were family members and were separate observations in the methods on page 4.**

	-And some minor comments: First paragraph “a target of funding incentives and quality metrics across health-care systems in Canada and the US” – how does this cause high rates of poor helath outcome and utilization? Do you mean that incentives that focus on “rapid discharge” result in high re-admission rates? **We have reworded our introduction on page 3 to improve the clarity of how funding incentives relate to our study and the inclusion of participants discharged with quality-based procedures.** -Second paragraph: “reducing readmission rates …… are a target of funding incentives in Canada”. Your 3 refs don’t really describe what this funding incentives are. I’d be curious for you to add this information to the paper. And do these funding incentives target providers or hospitals? And are the incentives? **We thank the reviewer for this excellent suggestion. We have reworded our two introductory paragraphs to help better explain funding incentives as part of health system reform on Page 3 and added an additional reference (now reference 10).** -Under study design, I’d suggest you mention in the 1st sentence that this is part of a large RCT (and give some more details on this study to start with). When did it start – is it ongoing? When will it be done? Also, it’s not clear if the discharge bundle was the only part of the intervention in the RCT? **We have clarified in the “participants” section on page 4 how the qualitative participants relate to the larger cohort of participants in the RCT, which is ongoing and for which participants in the intervention arm received an additional discharge instruction tool. We have also included all of the details of the RCT in a reference of the website link to the clinical trials registration.** -How effectively could you blind the research team to whether a patient received the discharge bundle? Did you test this? **We have clarified on page 4 how the research team had no role in the patient’s care or delivery of the intervention and therefore remain blinded to whether the patient received the intervention (additional discharge tool) versus usual discharge instructions.**