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Title: A qualitative study of older adult trauma survivors' experiences in acute care and early recovery
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Reviewer 1: Dr. Lara Khoury
Institution: The Ottawa Hospital
General comments (author response in bold)

This is an interesting study that tackles an important aspect of caring for older adults: their perception of the care they receive and the importance of being included in decision making to achieve patient- specific care outcomes.

I have a couple of comments:

1)- I would like to learn more about why the authors chose to look at potential age bias in older trauma population, potentially impeding care experiences and outcomes.
We thank the reviewer for this important question. We chose to look at age bias in this article because we identified this as a meaningful theme in our early interviews. This was discovered inductively, that is, we did not set out to identify age bias. Our objective was to characterize older adult injury survivors' experiences, which we found were predominantly influenced by perceptions of age bias.

Has age bias been described in past in older adults who suffer from trauma?
Age bias has not been specifically described previously in the older adult trauma survivor population, as far as we are aware.

Have there been other studies looking at age bias in and its correlation to care experiences and outcomes used?
To our knowledge there have not been any previous studies looking at the correlation of age bias experience to care experiences and outcomes in trauma care.

3)- In your paper, you talk about meaningful categories and themes being derived through frequent discussions among authors. Thematic analysis is quite a diverse method that is used and conceptualized differently by different researchers. It would be helpful to describe more clearly how you used the methodology, making the researchers' epistemological assumptions explicit, as this, as you know, is an important marker of rigor in qualitative research. For reference, see paper by Varpio et al. (2017):, where the authors describe how one can easily overlook the active role of the researcher in the process of analysis. As if "themes 'reside' in the data, and if we just look hard enough they will 'emerge' like Venus on the half shell. If themes 'reside' anywhere, they reside in our heads from our thinking about our data and creating links as we understand them." (Ely et al., 1997).
We appreciate the reviewer for noting the need for reflexivity and methodological clarity. Our analysis was indeed informed by our own subject positions as a social scientist (LGC) and clinician scientist (BH) in terms of being the primary analysts.

We have indicated an interpretivist approach on page 4 and have elaborated our subject positions on page 6. We have cited our thematic analysis approach on page 6.
We do not subscribe to the idea that themes reside in the data. We hope by acknowledging our subject positions and citing the literature used to inform the analysis the reader is provided with clarity on the analytic approach.

4)- The authors talk about older adults perceiving that there is age related bias in the care that they receive (page 15, last paragraph). While this may be true and it may be important to change some of the terms we use in the clinical notes, I do not how authors make the link that this has implications for accessing important age related trauma care and for improving overall outcomes.
We thank the reviewer for this note to clarify the discussion. We have edited/clarified to better explain the link between participant-perceived age bias and "engagement in" age-specific care. We have replaced the word "access to" with "engagement in" which is more appropriate. Please see Page 13.

The authors later add that long term outcome evaluations in the trauma population have shown that older age is a predictor of failed and no return to work after injury, but this was only studied in those aged 18-64 and not in those age 65 and over. While it may be important to look at these outcome measures in those aged 65 and over, what additional information would we hope to gain? Wouldn't older adults be at greater risk for not being able to return to work if age was found to be an independent risk factor? Perhaps I missed the intent of this particular discussion, but this highlights that perhaps there needs to be more clarity in this particular paragraph.
We have deleted this section of the discussion as it was not the most relevant to the main thematic findings reported.

5)- I really appreciated the second part of the discussion where authors discuss the sense of personal and social loss older adults experience after injury, thereby necessitating that we move beyond the medical and disease oriented model of care to a more integrated approach that takes into account subjective experiences of individuals. This may help health care providers use outcome measures that are more meaningful to older adults.
We thank the reviewer for the positive feedback on this section of the discussion.

Reviewer 2: Dr. Donna Goodridge
Institution: University of Saskatchewan
General comments (author response in bold)

Thank you for this interesting manuscript highlighting the complexity of the recovery process and the implications of ageism in the care process.

1. The stated objective appears to be to explore older adult trauma survivors' experiences up to six months in their recovery, to identify care process and outcomes they view to be of greatest value.
1. As noted above, we have clarified our objective was to characterize the experiences of injured older adults. Our long term goal is to inform patient-centred process and outcome for this patient population.

Each theme should be directly linked to the overall objective.

We have labeled each theme as reflecting an aspect of participant experience that influenced their hospital care or recovery experience and potentially their outcome.

Rationale is logically and clearly presented in the background section. The interviewer's personal characteristics are adequately described.
Thank you.

3. How was cognitive status assessed?
Thank you for this important question. For brevity, we have stated that "Eligibility was assessed by study coordinators responsible for recruitment." Page 5.
The elaborated process was as follows:
The research coordinator reviewed the chart for clinical notes on patient capacity (often noted in social work notes or follow up clinic visit note). If there was nothing exclusionary in the chart, the research coordinator approached the patient and applied the principles from the Modified Aid to Capacity Assessment when speaking to eligible participants at recruitment.

4. In terms of the first theme, "I don't feel like a senior", it is not clear how the preference not be identified as a senior had any impact on the overall objective examining valued care or processes. The quotes are all about the ways in which older adults identities have been constructed. This seems to be more of an incidental, but common, observation and not particularly relevant to the overall objective.
Thank you for the comment which has pushed us to clarify the writing in this section of the article. With this theme, we describe participants' own negative views of being senior or of older age in the context of their hospital care, and specifically senior-friendly care.
We have edited the text to improve our explanation of this theme as in the context of hospital care and SFC strategy. Please see Page 8.

5. The second theme relates more clearly to the impact on care and processes, but only the final quote provides evidence supporting this theme. While I agree with the perceptions voiced in the quotes, they reflect general societal attitudes rather than interactions with the health care system. The third quote does not seem to fit well here and relates to experiences as a child.
Thank you for the comment which again has pushed us to clarify the writing in this section. With this theme, we describe the persistence of these general societal attitudes *despite the presence of the SFC strategy in these settings*. We have clarified that these quotes are in the context of medical assessment and/or asking questions about their care.
In the third quote, the participant is drawing similarities between how doctors and nurses interact with older adults and how they interact with children.
Please see Page 9.

6. The third and fourth themes are well-supported by the selected quotes and relevant to the objective, although these are findings are not novel in the geriatric literature and reflect the common experience of many older adults after a health crisis. There is very little in the manuscript that is specific to trauma and after-care.
Thank you for noting the relevance of the themes and supporting quotes. We agree that these findings are consistent with the experiences of older adults after

health crises other than injury. However, these findings have not been reported in an injury-specific population, which is a gap in the literature.
As noted in our discussion and through reference to Nathens et al.'s 2016 article, injury care has only recently sought to consider patient-centred outcomes (such as mental-health related outcomes) in quality metrics. As such, our findings describing the intersection of injury and aging are novel and specific to trauma and after-care in an important way that may lead to improvements in this field.