Technical Brief Disposition of Comments Report

Research Review Title: *Resident Safety Practices in Nursing Home Settings*

Draft review available for public comment from October 30, 2015 to November 25, 2015.

Research Review Citation: Simmons S, Schnelle J, Slagle J, Sathe NA, Stevenson D, Carlo M, McPheeters ML. Resident Safety Practices in Nursing Home Settings. Technical Brief No. 24. (Prepared by the Vanderbilt Evidence-based Practice Center under Contract No. 290-2015-00003-I.) AHRQ Publication No. 16-EHC022-EF. Rockville, MD: Agency for Healthcare Research and Quality; May 2016. www.effectivehealthcare.ahrq.gov/reports/final.cfm.

Comments to Research Review

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The tables below include the responses by the authors of the review to each comment that was submitted for this draft review. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.

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#	Commentator & Affiliation	Section	Comment	Response
1.	Peer reviewer #1	Background	8, 18: [abstract] What literature was searched? Much should be gray not covered in previous reviews.	We did not search the grey literature due to the volume of peer-reviewed literature available for use in this report.
2.	Peer reviewer #1	Background	[abstract line 21] 21: How big a problem is it? How does it vary with homes? [text referenced is Nursing home resident safety results from the interplay of resident characteristics and needs within the context of staffing and programmatic decisions that are influenced by various payment and regulatory models.]	We have modified the abstract to note that defining safety in the nursing home context must take into account contextual factors; future research should begin to quantify how safety differs in these variable and complex settings.
3.	Peer reviewer #1	Background	[abstract line 43]: Is QOL a trade-off for all safety questions? Falls yes but infections, pressure ulcers?	We have revised the abstract to note the trade-off between QoL and some types of adverse events.
4.	Peer reviewer #1	Background	[background/structure of nursing home pg.1] 9, 17: Includes assisted living? P 10, 4 implies yes	We have targeted the background extensively and this information no longer appears.
5.	Peer reviewer #1	Background	[background/figure 1, pg1] 51: Is the issue transitions?	We have targeted the background extensively and this information no longer appears.
6.	Peer reviewer #1	Background	[background/nursing home safety] 10, 47: 7.96 overall deficiencies or safety-related?	This text refers to overall deficiencies, and further in the paragraph we describe safety related rates.
7.	Peer reviewer #1	Background	[background/nursing home safety pg 2] 54: 6.1 deficiencies	We have corrected the text to note “an average of 6.1 health deficiency citations.”
8.	Peer reviewer #1	Background	[background/Approaches to studying NH safety] 11, 36: approaches to studying NH safety or interventions to reduce problems/increase safety?	We have targeted the report extensively and this information no longer appears.
9.	Peer reviewer #1	Background	[background/Approaches to studying NH safety] 54: prospective uncontrolled vs. observational controlled designs. Problems with the former are extensive.	We have targeted the report extensively and this information no longer appears.
10.	Peer reviewer #1	Background	[Background/Approaches to studying NH safety]12, 6: secondary analyses do not typically address interventions; might show associations as noted but dubious value	We have targeted the report extensively and this information no longer appears.
11.	Peer reviewer #1	Background	[Background Table 3, pg. 5] 29: Need to distinguish incidence/prevalence from interventions	We have targeted the report extensively and this information no longer appears.
12.	Peer reviewer #1	Background	13, 15: Claims provide littler basis for safety analyses. Can sometimes detect ED use for injuries but very imprecise	We have targeted the report extensively and this information no longer appears.

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13.	Peer reviewer #1	Background	[Background/Technical Brief Objectives,] 41: Here it suggest the goal is directed toward intervention. By now I am thoroughly confused about the purpose.	We have clarified that the goals of this Technical Brief are to describe the state of current intervention science in addressing safety in the nursing home setting and in so doing, to provide a research agenda for future work.
14.	Peer reviewer #1	Background	[Background/Technical Brief Objectives, Table 3] 28: direct observation looks at practices but not events	We have targeted the report extensively and this information no longer appears.
15.	Peer reviewer #1	Background	[Background/Technical Brief Objectives] 49: Here it says it is describing safety practices	We have clarified that the goals of this Technical Brief are to describe the state of current intervention science in addressing safety in the nursing home setting and in so doing, to provide a research agenda for future work. The development of the research agenda is the primary focus.
16.	Peer reviewer #1	Background	[Background/Technical Brief Overview] 14, 12: very high level overview of what?	We have revised this statement to note that the brief provides an overview of nursing home resident safety-related issues.
17.	Peer reviewer #1	Background	[Background/Technical Brief Objectives] 53: reviews address range of NH safety topics; how many are relevant to charge above?	We have targeted the report extensively and this information no longer appears.
18.	Peer reviewer #1	Background	[Background/Report organization] 28: GQ 1 has two components on safety issues and one on hospital interventions. Why combine them?	We determined the KQ in conjunction with our TOO and with technical expert input. Stakeholders with whom we spoke felt these questions were important to address.
19.	Peer reviewer #1	Background	[Background/Report Organization], 40: GQ2a (there is no b): settings for assessing safety or factors that may influence incidence or effectiveness of interventions?	Our key questions are based first on a standard set of questions for AHRQ technical briefs, and then modified in conjunction with key informants and our Task Order Officer.
20.	Peer reviewer #1	Background	[Background/Report Organization] 49: No GQ3b either	We have eliminated the “a.”
21.	Peer reviewer #2	Background	Background: The Background appears thorough, organized, and well written.	Thank you for your comment.
22.	Peer reviewer #3	Background	Background: The background provides some useful information, as well as building blocks for the rest of the technical brief. The authors should ensure that each of the facility characteristics that may impact safety and that are mentioned later in the report are added to Table 2 or added to the supporting text.	The entire background section is substantially revised. We believe that it continues to provide the appropriate background for the brief.

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23.	Peer reviewer #4	Background	Background: This section describes the clinical problem very well. In the approaches to studying nursing home safety summary, I recommend that cross sectional and/or descriptive study approaches used to assess dimensions of safety culture and their associations with other variables of interest are included. For example, communication openness, non-punitive response to error, teamwork across units, and management support for patient safety are safety dimension that have been described and associated with clinical outcomes. Nursing home management and leadership staff will benefit from understanding the influence of work context on the effectiveness of any safety-focused interventions.	We have targeted the report extensively and this information no longer appears
24.	Peer reviewer #5	Background	Background: page 11-lines 27-32 They discuss the susceptibility of residents to adverse events but do not discuss at all about the way care is provided in nursing homes here and how that can lead to adverse events. Here they should discuss the role of nursing homes and why what they do may be inadequate for assuring safety-- low staffing, little attention to prevention of adverse events, training, etc.	The report is focused on safety within nursing homes, and we address the need for much more research/discussion on organizational and staffing issues in the future research.
25.	Peer reviewer #5	Background	The scope should be moved earlier in the document.	We have clarified the scope of the report, but also adhere to the organizational structure required for a technical brief.
26.	Peer reviewer #5	Background	The list of adverse events is organized poorly. Potentially contributing factors, in some cases reflect potential harm to the person, in other cases it may reflect normal decline. Avoidable decline in ADLS may be viewed as harm not a potentially contributing factor to an adverse event.	We have noted that some potentially contributing factors may not be possible to mitigate or avoid in some populations.
27.	Peer reviewer #5	Background	Why is dementia not a contributing event?This is not straight forward and the dichotomy that is posited does not work well.	We agree that dementia is an important and significant underlying issue in this population that may set the stage for safety events; however, we could not explicitly address every precursor in the context of a technical brief. We note that the impact of dementia on safety is an important area for future research.
28.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Background	p. viii Consider replacing the term “person-centeredness” and “person-centered care” with “person-directed” care throughout the report. In a nutshell, in the former we (professionals; researchers; policy makers) assume what’s good for the resident. In the latter, we seek input directly from the person. As advocated by Dr. Allen Power, author of the books Dementia Beyond Drugs and Dementia Beyond Disease.	Our use of the term person-centered reflects that used by our key informants and in the literature we identified.

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29.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Background	Key adverse events also include the prevalent, concerning, but under-recognized public health problem of episodes of resident-to-resident altercations in the context of dementia and serious mental illness (behavioral expressions commonly labeled “aggressive”) resulting in psychological harm, falls (e.g., “push-fall” episodes), injuries (e.g., hip fracture and brain injury), and deaths subsequent to these injuries. My upcoming Editorial in JAMDA (scheduled to be published on Dec 30 2015 for January issue) reviews the circumstances surrounding the deaths of 40 older adults as a result of resident-to-resident altercations in dementia in LTC homes: Caspi, E. (in press). Deaths as a result of resident-to-resident altercations in dementia in long-term care homes: A need for research, policy, and prevention. Journal of the American Medical Directors Association. [Editorial]	Thank you for your comment. We have noted this an important area that was out of scope for the current report.
30.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Background	Acknowledge safety problems in assisted living residences, the fastest growing residential care option for older adults in the U.S. For example, as reported in the PBS film *Life and Death in Assisted Living.* In addition, studies show that over 40% of assisted living residents have dementia and many of these residents experience various forms of behavioral expressions, which can lead to adverse events. I now see that you do dedicate a segment later on in the report about this setting, which is great!	Thank you for your comment.
31.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Background	For example, my 10-month direct observation study was the first to examine resident-to-resident altercations in dementia in assisted living residence: Caspi, E. (2015). Aggressive behaviors between residents with dementia in an assisted living residence. *Dementia: The International Journal of Social Research and Practice, 14(4),* 528-546. The same study revealed numerous care-related problems and safety issues during time periods when residents with dementia where left alone unsupervised for significant periods: Caspi, E. (2014). Does self-neglect occur among older adults with dementia when unsupervised in Assisted Living? An exploratory, observational study. *Journal of Elder Abuse and Neglect, 26(2),* 123-149.	Thank you for your comment.

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32.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Background	Consider replacing the term "facility" to "long-term care home" or "care home" throughout. The term "facility" belongs to the old culture of care. These residences are older residents' homes.	We have considered this and decided to leave the text as is.
33.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Background	Page 2. Avoid using the term "elderly." Instead, use terms such as "elders," "older adults," and seniors. See Editorial entitled Agesim in Gerontological Language by Prof. Erdman Palmore (2000) in *The Gerontologist, 40(6),* 645.	We have made this change throughout.
34.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Background	Page 2. When discussing falls, it is important to cite studies indicating that significant number of falls are caused by physical altercations between residents (push-fall episodes). For example, One study using video recordings of 227 falls among 130 older residents in common spaces of two LTC homes has found that 20 of these falls (9%) occurred during episodes of altercations between residents: Rabinovitch SN, Feldman F, Yang Y, et al. Video capture of the circumstances of falls in elderly people residing in long-term care: An observational study. *The Lancet*. 2013;381(9860):47-54.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.
35.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Background	A major gap in the MDS 3.0 (Behavior E Section) is that it does not make the distinction between behavioral expressions commonly labeled "aggressive" directed from one resident towards another versus those directed towards staff members. Please see my Letter to the Editor of JAMDA addressing this major and persistent barrier in practice and research: Caspi, E. (2013). M.D.S. 3.0 – A giant step forward but what about items on resident-to- resident aggression? *Journal of the American Medical Directors Association, 14(8),* 624-625.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.
36.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Background	Page 3. Please cite this RCT in NHs examining effects of staff training program for improved recognition and prevention of resident-to-resident altercations: Teresi, J.A., Ramirez, M., Ellis, J., Silver, S., Boratgis, G., Kong, J., Eimicke, J.P., Pillemer, K., & Lachs, M. (2013a). A staff intervention targeting resident-to-resident elder mistreatment (R-REM) in long-term care increased staff knowledge, recognition, and reporting: Results from a cluster randomized trial. *International Journal of Nursing Studies, 50,* 644-656.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.

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37.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Background	Page 5. Table 3. Data Source. Direct observation. Under Limitations' column. Please see my unpublished manuscript on the major but often overlooked inherent limitation in the majority of observation instruments/schedules focusing on behavioral expressions in LTC residents with dementia: Caspi, E. (2012). Rigor versus relevance in structured observational strategies in research on behavioral expressions in persons with dementia. Link: http://tinyurl.com/lekobe2	Thank you for your comment.
38.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Background	Consider acknowledging the need for states' and national strategy for addressing resident-to-resident altercations in the context of dementia in LTC homes: Caspi, E. (2015). Policy Recommendation: The National Center for Prevention of Resident-to-Resident Aggression in Dementia. *Journal of the American Medical Directors Association, 16,* 527-534.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.
39.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Background	See note, suggestion, and citation (Letter to the Editor of AMDA above) about the major gap in the MDS 3.0 pertaining to resident-to-resident altercations.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.
40.	Peer reviewer #1	Clarity and Usability	It would be better to say less more clearly. Some of the tables are quite helpful and could b made more useful. Can you define a succinct set of major messages that would help your target audience? Who is your target audience?	We have revised the report extensively throughout to improve clarity and focus. We note that the report is intended to identify areas for future research.
41.	Peer reviewer #2	Clarity and Usability	Clarity and Usability: I think the report is clear and usable to help guide a lot of important future research	Thank you for your comment.
42.	Peer reviewer #3	Clarity and Usability	Clarity and Usability: I think that the report is well-written and clearly communicated. My concern is that it doesn't precisely inform us about the next steps to take. The authors should take reasonable leaps of faith and help guide AHRQ and other readers of this report so that we can allocate appropriate resources to answer the questions posed or suggested as potential next steps in this report.	We have revised the Next Steps section of the report and hope that it will better inform future research in this area.
43.	Peer reviewer #4	Clarity and Usability	Clarity and Usability: I think this brief is very well written, structured, and organized. The main points are made clearly and it may be used to inform future research. The evidence tables, other tables, and materials included in the appendix were excellent.	Thank you for your comments.
44.	Peer reviewer #5	Clarity and Usability	Clarity and Usability: This document is not clear and as is it is not suitable for publication	We have revised the document throughout to improve clarity and usability.

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45.	Peer reviewer #1	Findings	[Findings/GQ1a] 18, 31: The NH context is thus across between hospital and home but where is the philosophic line drawn? How much risk tolerance is permitted in a highly regulated environment? This is fundamental to how we approach any discussion about safety in NHs. Some elements of safety involve risk more than others. Would it be helpful to first identify "never" events as with hospitals?	We believe that this is one of the open questions that the field should address in moving the research forward. Certainly these questions are fundamentally important, but they are not answerable in the context of the technical brief.
46.	Peer reviewer #1	Findings	Table 5, pg. 11: What about state NH survey reports? Several F tags reflect safety issues?	This information no longer appears.
47.	Peer reviewer #1	Findings	[Findings/GQ1a] 37: What are the 10 conditions? Are these risk factors? Should safety programs work on reducing them or just use them as warning signs?	We have revised the report extensively and the concept of warning signs or precursors as a safety issue is recommended as a potential area of future research, rather than being reviewed as safety issues.
48.	Peer reviewer #1	Findings	Table 6: see questions from Table 4	We have targeted the report extensively and this information no longer appears.
49.	Peer reviewer #1	Findings	[Findings/GQ1a] 20, 24: Omissions are undoubtedly important but how do they relate to interventions?	The report notes that care omissions may result in lapses in safety and thus may be an area for future research.
50.	Peer reviewer #1	Findings	[Findings/GQ1a] 21, 20: Preferences should identify specifically risk tolerance. This is a big issue and a subtle one. Being willing to take risks does not mean abandoning concerns about safety. First, this is topic specific; wanting to walk at the risk of falls does not mean abandoning all other safety areas. Second, there is sometimes exclusion of persons at end of life.	We have revised this section to focus on safety issues as defined in Patient Safety Organization Privacy Protection Center (PSOPPC) Common Formats for Event Reporting on Nursing Home Safety Version 0.1 Beta (PSOPPC Common Formats).
51.	Peer reviewer #1	Findings	[Findings/GQ1b] 22, 19: The other important transition is to and from the ED. Changes in medications and care plans raise opportunities for mischief.	We have noted that transitions of care may include to and from the emergency department.
52.	Peer reviewer #1	Findings	[Findings/GQ1b] 47: How is discharge home from a NH different from discharge from hospital?	It is not clear if the issues involved with transition from the hospital directly to home are different than those involved with transition from long term care or SNF stay to home, but in both cases problems leading to adverse events and readmissions have been documented. We have noted that transitions of care may include from a nursing home to home and may create vulnerabilities for safety events.

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53.	Peer reviewer #1	Findings	[Findings/GQ1c,] 23, 17: How does the hospital setting differ from NH with regard to potential for safety interventions?	Section GQ1c addresses differences in setting that may affect safety interventions.
54.	Peer reviewer #1	Findings	[Findings/GQ1c] 50: Is this just an unrated list? How many seemed to be effective? (Even if not a systematic review some information on effectiveness would be helpful.)	This section focuses on hospital implemented interventions that address the areas outlined in the PSOPPC Common Formats.
55.	Peer reviewer #1	Findings	[Findings/GQ1c] 24, 4: This is an area where staffing differences are very salient.	We agree but have moved discussion of staffing issues to a future research suggestion, in particular focusing on the need to elucidate the link between staffing and safety.
56.	Peer reviewer #1	Findings	[Findings/GQ1c] 17: Separate prescribing errors from dispensing errors	We have noted that studies cited address both prescribing and dispensing errors.
57.	Peer reviewer #1	Findings	[Findings/GQ1c] 34: Again, what works?	The role of this brief is to lay out the available science and develop a research agenda, not to review the evidence
58.	Peer reviewer #1	Findings	[Findings/GQ1c] 25, 4: Payment policy is intriguing. The basis of RUGs is quite different from DRGs. What are the implications? Would you penalize decreases in function, for example?	This is an excellent question, and one that could form an area for research. We are not making policy recommendations in this brief.
59.	Peer reviewer #1	Findings	[Findings/GQ2a] 26, 7: So what are the implications of these resident characteristics?	We have modified the report extensively and this information no longer appears.
60.	Peer reviewer #1	Findings	[Findings/GQ2a] 58: Data on the relationship of LPNs and quality is confusingly mixed.	We have modified the report extensively and this information no longer appears.
61.	Peer reviewer #1	Findings	[Findings/GQ2a] 27, 11: Need to identify the risks of confounding staff and other factors that affect quality.	We have modified the report extensively and this information no longer appears.
62.	Peer reviewer #1	Findings	[Findings/GQ2a] 38: Recommendations for staffing levels are controversial.	We have modified the report extensively and this information no longer appears.
63.	Peer reviewer #1	Findings	[Findings/GQ3] 28, 34: Does the table summarize evaluating AEs or interventions?	We have revised this sentence to note that the table provides a review of interventions to prevent adverse events.
64.	Peer reviewer #1	Findings	[Findings/GQ3] 41: ROB does not typically apply to reviews. SOE is more relevant.	Risk of bias in this KQ typically refers to the ROBIS risk of bias tool to assess the conduct of systematic reviews. We disagree that SOE is relevant as we can only count on SOE for a given review IF the methods used in that review are sound. SOE is also strongly dependent on the quality of the individual studies included in the reviews and we have not re-reviewed the individual studies.

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65.	Peer reviewer #1	Findings	Table 8: 1st row: Do we conclude that none of the 8 intervention's worked?	These tables are meant to provide a broad overview of the focus and general findings of prior reviews, in line with the purpose of technical briefs to offer an outline of current science and inform future research directions.
66.	Peer reviewer #1	Findings	Table 8: 2nd row: Hip protectors: What does "small" mean?	We have eliminated "small."
67.	Peer reviewer #1	Findings	Table 8: 3rd row: 7 interventions described; results for only a few given	These tables are meant to provide a broad overview of the focus and general findings of prior reviews, in line with the purpose of technical briefs to offer an outline of current evidence and inform future research directions.
68.	Peer reviewer #1	Findings	Table 8: 4th row: Low be height can actually increase fall rates	This was the intervention studied in this particular review.
69.	Peer reviewer #1	Findings	Table 8 5th row: limited evidence but low ROBIS. What does that mean?	ROBIS assesses the conduct of the systematic review, not the results of studies included in the review. Thus, a well-conducted review (low risk of bias) may include primary research studies of limited quality.
70.	Peer reviewer #1	Findings	Table 8: 6th row: again many interventions and fewer reported	These tables are meant to provide a broad overview of the focus and general findings of prior reviews, in line with the purpose of technical briefs to offer an outline of current evidence and inform future research directions.
71.	Peer reviewer #1	Findings	Table 8 7th row: Combine/juxtapose hip protector reviews Decrease here but low above. What do these terms mean?	These tables are meant to provide a broad overview of the focus and general findings of prior reviews, in line with the purpose of technical briefs to offer an outline of current evidence and inform future research directions.
72.	Peer reviewer #1	Findings	Table 8: 8th row: Now more research needed. What do these three reviews tell us?	In no area of research were the reviews consistent either in their approach or conclusions. Furthermore, there are new studies that should be incorporated into reviews. Thus, further research is needed.

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73.	Peer reviewer #1	Findings	Table 8: 9th row: juxtapose exercise studies	These tables are meant to provide a broad overview of the focus and general findings of prior reviews, in line with the purpose of technical briefs to offer an outline of current evidence and inform future research directions.
74.	Peer reviewer #1	Findings	Table 8: 10th row: Mixed bag no effect	As noted above, reviews were inconsistent in all areas.
75.	Peer reviewer #1	Findings	Table 8: 11th: What is fall prevention as an intervention? Seems to work, but…	We have expanded the description of interventions addressed in the review described.
76.	Peer reviewer #1	Findings	Table 8: 12th row: Juxtapose Vitamin D studies	These tables are meant to provide a broad overview of the focus and general findings of prior reviews, in line with the purpose of technical briefs to offer an outline of current evidence and inform future research directions.
77.	Peer reviewer #1	Findings	Table 8: 13th row: What does multifaceted mean? Needs to be more detailed.	We have added more information on the interventions addressed.
78.	Peer reviewer #1	Findings	33: Table 9 is helpful. It would be better if you used some sign (e.g., + -) to show direction of effect, if any, and bold for significant changes.	Not all reviews provided an overall synthesis of direction of effect, and direction of effect may have varied depending on the intervention in reviews addressing more than one type of intervention so unfortunately this is not a simple thing to do.
79.	Peer reviewer #1	Findings	34: Table 10 is less helpful but ok. It says nothing about outcomes.	The goal of this table is to provide an overview of the types of interventions that have been studied. We hope that it will be useful for those less familiar with the literature in this field.
80.	Peer reviewer #1	Findings	[Findings/GQ3] 35, 12: What is a comparative study? Not an RCT? Did the review focus exclusively on mattresses or is there a reporting bias?	We have noted that the review included studies with intervention and comparison groups; in other words, no case series or other such studies that do not include separate comparators.
81.	Peer reviewer #1	Findings	[Findings/GQ3] 19: Were the results different for RCTs and observational studies?	This section provides a high-level overview of findings, in line with the purpose of technical briefs to offer an outline of current evidence and inform future research directions.
82.	Peer reviewer #1	Findings	Table 11: 1st row: typo in last column “tilt”.	Corrected, thank you.

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83.	Peer reviewer #1	Findings	Table 11: 2nd row: Interventions and conclusions don't align	We have revised the description of this review.
84.	Peer reviewer #1	Findings	Table 11: 3rd row: More interventions than results	As noted previously, the goal of a technical brief is to outline how much literature is available and of what type, rather than to provide results and conclusions for interventions. Thus, the reviewer is correct that the report is more descriptive of the interventions. This is especially the case as we reviewed reviews rather than primary studies.
85.	Peer reviewer #1	Findings	Table 11: 4th row: Interventions and conclusions don't align	We have revised the description of this review.
86.	Peer reviewer #1	Findings	Table 11: 5th row: Conclusions very general and vague	Unfortunately, many reviews do not provide extremely specific conclusions to summarize.
87.	Peer reviewer #1	Findings	Table 11: 6th row: Conclusions very general and vague	Unfortunately, many reviews do not provide extremely specific conclusions to summarize.
88.	Peer reviewer #1	Findings	Table 11: 8th row: Interventions don't make sense	We have revised the description of this review.
89.	Peer reviewer #1	Findings	Table 11: 9th row: "Treatments" seems very vague	We have revised the description of this review.
90.	Peer reviewer #1	Findings	[Findings/GQ3] 37, 40: This seems like a very mixed bag with several non-useful reviews	As noted above, reviews were inconsistent in all areas.
91.	Peer reviewer #1	Findings	[Findings/GQ3] 41: Basis for choosing reviews for Table 12 is not clear. It is not just vaccinations	The reviews in this table address interventions for infection prevention.
92.	Peer reviewer #1	Findings	Table 12 1st row: "infection prevention and control" is not a useful intervention descriptor 2nd row: Neither is "Non pharmacological infection-prevention interventions"	We have added more detail on these interventions.
93.	Peer reviewer #1	Findings	[Findings/GQ3] 38, 55: I don't understand the distinction between study ROB and review ROB	The RoB for systematic reviews (assessed using the ROBIS tool) refers to the rigor of the methods used to conduct the systemic review and is not related to the RoB of individual studies included in the review. A very well done review (low RoB) may address studies that are considered to have high RoB.

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94.	Peer reviewer #1	Findings	[Findings/GQ3] 39, 11: Can you distinguish inappropriate use from medication safety? Presumably the latter addressees poor choices or dosages? Virtually all of these seem to address prescribing issues as opposed to dispensing errors.	This is an excellent point. After consideration by the team we did not choose to separate the issues for the technical brief as they are related; however, future research should be clear about what type of problem is being addressed.
95.	Peer reviewer #1	Findings	Table 13: 1st row: hydration? Is hydration a medication? Conclusions confusing	We have clarified the wording in this table, which is now included in an appendix.
96.	Peer reviewer #1	Findings	Table 13: 2nd row: Inappropriate prescribing vs. polypharmacy? They are not the same	We considered adverse drug events broadly and included reviews addressing both polypharmacy and medication errors.
97.	Peer reviewer #1	Findings	Table 13: 3rd row: Medication reviews by whom (presumably a pharmacist)? What was done with them?	We have clarified the wording in this table, which is now included in an appendix.
98.	Peer reviewer #1	Findings	Table 13: 5th row: “May improve antibiotic prescribing”?	We considered adverse drug events broadly and included reviews addressing both polypharmacy and medication errors.
99.	Peer reviewer #1	Findings	Table 13: 7th row: “Educational interventions, alone or in conjunction with pharmacist review, may reduce inappropriate drug use.” Pretty vague	These tables are meant to provide a broad overview of the focus and general findings of prior reviews, in line with the purpose of technical briefs to offer an outline of current evidence and inform future research directions.
100.	Peer reviewer #1	Findings	Table 14: title misleading. These are not about medication errors or even AEs	This table reports on focus of interventions described in reviews of interventions targeting medication errors or ADEs.
101.	Peer reviewer #1	Findings	Table 15: 2nd row: Again, vague outcome. What outcomes? Weight? “May”	These tables are meant to provide a broad overview of the focus and general findings of prior reviews, in line with the purpose of technical briefs to offer an outline of current evidence and inform future research directions

#	Commentator & Affiliation	Section	Comment	Response
102.	Peer reviewer #1	Findings	[Findings/GQ3] 44, 23: Is ADL decline a safety issue? Exercise is typically targeted at falls.	We have significantly modified the report to focus on the four safety issues identified in AHRQ's Common Format. The other areas are considered potential targets for future research efforts on establishing an appropriate definition of safety in the nursing home context.
103.	Peer reviewer #1	Findings	[Findings/GQ3] 46, 29: Again, is this a safety issue?	We have significantly modified the report to focus on the four safety issues identified in AHRQ's Common Format. The other areas are considered potential targets for future research efforts on establishing an appropriate definition of safety in the nursing home context.
104.	Peer reviewer #1	Findings	Table 17: 1st row: No real outcomes information 4th row: Is this also evidence of failure to sustain the effect?	We have modified the report extensively and this information no longer appears.
105.	Peer reviewer #1	Findings	[Findings/GQ3] 49, 13: Again, is this a safety issue?	We have significantly modified the report to focus on the four safety issues identified in AHRQ's Common Format. The other areas are considered potential targets for future research efforts on establishing an appropriate definition of safety in the nursing home context.
106.	Peer reviewer #1	Findings	[Findings/GQ3] 21: Where is the data on the 38 RCTs you ungoverned?	The Technical Brief is not meant to summarize findings of these studies but rather to indicate where research exists and areas for additional study. We have included a listing of the newly published studies identified as an appendix.
107.	Peer reviewer #1	Findings	Table 18: 2nd row: Where does hospitalization come in? Is that integrated care?	We have targeted the report extensively and this information no longer appears.
108.	Peer reviewer #1	Findings	Table 19 3rd row: EPC systematic review of non-pharmacological approaches to reducing agitation and aggression is not encouraging. It is not posted yet, but you may want to see it. 52, 4: Again, is this a safety issue?	We have targeted the report extensively and this information no longer appears.
109.	Peer reviewer #1	Findings	[Findings/GQ3] 52, 4: Again, is this a safety issue?	We have targeted the report extensively and this information no longer appears.

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110.	Peer reviewer #1	Findings	Table 23: 1st row: Is boredom safety? 2nd row: Is challenging behavior safety?	We have targeted the report extensively and this information no longer appears.
111.	Peer reviewer #1	Findings	Table 24: This might fit better earlier when staffing is discussed 1st row:	We have targeted the report extensively and this information no longer appears.
112.	Peer reviewer #1	Findings	Table 24:How is QOC related to safety?	We have targeted the report extensively and this information no longer appears.
113.	Peer reviewer #1	Findings	Table 24:2nd row: Conclusions don't seem relevant 4th row: Can conclusions identify where the interventions worked?	We have revised the text for the table rows indicated.
114.	Peer reviewer #1	Findings	Table 25: dos the middle column mean no pre data? Can you show patterns of effect as suggested for Table 9?	This table provides estimates of new studies by study design. It was not the purpose of this report to assess the outcomes reported in each study (rather it provides a broad map of the literature); thus, we cannot comment on direction of effect.
115.	Peer reviewer #1	Findings	[Findings/GQ4a] 59, 4: Can uptake be expanded to include sustainability?	Certainly, sustainability could be an important part of uptake, but that was not something we addressed in this report.
116.	Peer reviewer #1	Findings	[Findings/GQ4a] 13: So the problem is not uptake but evidence?	One expects that evidence should drive uptake, but as noted in GQ3, there appears to be a lack of consistency in available evidence.
117.	Peer reviewer #1	Findings	[Findings/GQ4a] 27: What about resources available to implement the changes (a favorite topic of the author)?	We note that implementation data on interventions, including staffing resources needed, is lacking and may be a barrier to uptake.
118.	Peer reviewer #1	Findings	[Findings/GQ4a1] 31: You're a,b,c are different from your 1,2, 3 below	Actually, a/b/c are the same as 1/2/3 in this section although they may be worded just slightly differently.
119.	Peer reviewer #1	Findings	[Findings/GQ4a,1] 32: Do you mean lack of a meaningful effect from the intervention? That is a different matter. That addresses the strength of evidence.	The text we believe this comment is referencing ("First, limited evidence exists on expected levels of different safety outcomes, given that some degree of decline and associated clinical events will certainly occur in this vulnerable and complex population.") refers to a lack of understanding of the incidence of safety events relative to normal change that occur with aging.

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120.	Peer reviewer #1	Findings	[Findings/GQ4a] 42: Is this case mix concerns?	It is possible that these issues reflect case mix concerns to some degree. Regardless, empirical validation evidence is needed tying quality measures/assessment to actual quality.
121.	Peer reviewer #1	Findings	[Findings/GQ4a] 49: This was not in your a,b,c above	Actually, a/b/c are the same as 1/2/3 in this section although they may be worded just slightly differently.
122.	Peer reviewer #1	Findings	[Findings/GQ4b] 60, 25: Capturing implementation issues is much broader than suggested here. It includes leadership, payment, regulation.	We absolutely agree; the issues that we listed are a starting point, but much more detailed information on the breadth of implementation issues is needed.
123.	Peer reviewer #1	Findings	[Findings/GQ4b] 53: Will goals be adjusted for case mix?	This would be a decision for future researchers.
124.	Peer reviewer #1	Findings	[Findings/GQ4b] 61, 23: Need to address confounding	Certainly, good assessment and management of confounding is a fundamental methodological goal in any research.
125.	Peer reviewer #1	Findings	[Findings/GQ4b] 62, 8: How much is training and how much systems?	We would expect this question to form part of the research in the future.
126.	Peer reviewer #1	Findings	[Findings/GQ4b] 51: Is this really about risk aversion or does it go more deeply?	This is a good question, but it would be speculative to answer it here.
127.	Peer reviewer #1	Findings	[Findings/GQ4b] 63, 43: Wasn't extrapolating from hospital experience part of your charge?	Yes, as noted we were asked to assess whether it was appropriate or feasible to extrapolate from the hospital experience to the nursing home. For the reasons noted, it does not seem appropriate to do so without much deeper consideration of the applicability of what is known in the hospital setting. As we note explicitly, there is no evidence that hospital based interventions have or could translate clearly and easily to the nursing home setting.
128.	Peer reviewer #1	Findings	[Findings/GQ4c] 65, 34: The big shift is to HCBS. Does this apply there or only to intuitions like NHs and ALFs?	The core focus of this review is on the nursing home setting.
129.	Peer reviewer #2	Findings	Findings: The results are presented thoroughly and clearly.	Thank you for your comment.
130.	Peer reviewer #2	Findings	My only recommendation is similar to above. Subdivide this section into two subsections. One on interventions for major safety outcomes, and one on interventions for potentially contributing factors.	We have restructured our presentation of safety issues.

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131.	Peer reviewer #2	Findings	Another example is Table 25. It mixes primary outcomes with potential contributing factors. Differentiating these two categories seems important conceptually	We have restructured our presentation of safety issues.
132.	Peer reviewer #3	Findings	Findings: G1 Under medication errors, the authors should consider directly mentioning bar code medication administration. There are studies that have been published specifically in the nursing home setting that should be included. Many nursing homes have an electronic medication administration record system and some already have this capability.	We have added information to address this point in GQ1c.
133.	Peer reviewer #3	Findings	Q4. Approaches to managing polypharmacy should consider focusing on high-risk medication (i.e., national action plan for adverse drug event prevention), impact of medication reconciliation, use of new technologies that can increase availability of appropriate clinicians (e.g. telemedicine) can improve outcomes.	We agree that these are excellent ideas for future research.
134.	Peer reviewer #4	Findings	Findings: GQ1a. What are the safety issues of particular concern in the nursing home setting? The findings presented under GQ1a are comprehensive and well summarized in the evidence map. The inclusion of findings related to person-centered care and safety in nursing homes is very important. Clinical staff is challenged to use evidence-based practices that help them strike a balance between resident choice/preferences and safety (as demonstrated by regulatory compliance).	Thank you for your comment.
135.	Peer reviewer #4	Findings	Findings: GQ1a. It will be important for researchers to examine practices used to determine the decision-making capacity of mildly to moderately cognitively impaired residents who wish to choose activities that are potentially high risk for themselves and/or the nursing home.	Certainly we agree that the cognitive capabilities of residents should be considered within the context of future research.
136.	Peer reviewer #4	Findings	Findings: GQ1a. I understand that the technical brief has a defined scope. But I wonder about the exclusion of research findings focused on elopement or abuse in the nursing home setting.	We have noted abuse as an area that was out of scope for the current report. We agree that these are important issues for additional research.
137.	Peer reviewer #4	Findings	GQ1b. Are there important differences in safety issues for short-stay versus long-stay residents? The cognitive status of a long-stay resident may an important difference in safety issues, particularly in light of the emphasis on resident choice and preferences being honored.	Future work informed by this Technical brief may address this kind of issue.
138.	Peer reviewer #4	Findings	GQ1c. Are there specific safety interventions that have improved patient safety in the hospital setting that could transfer to the nursing home setting, but have yet to be tested as such? The information in this section is clearly identified, appropriately integrated, and balanced.	Thank you for your comment.

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139.	Peer reviewer #4	Findings	GQ2a. What characteristics and qualities of nursing homes and nursing home residents create unique settings for assessing safety and may affect choice of intervention and success rates? Given the limited number and educational preparation of RNs and DONs in nursing homes, it may be useful to study the 'surveillance capacity' of nursing homes, similar to studies that have been conducted in acute care. Absence of patient monitoring was one of the three categories related to potentially preventable adverse events reported in the OIG study.	The reviewer has identified a number of important potential confounders and modifiers of intervention success; we agree that assessment of these factors should be a part of future research.
140.	Peer reviewer #4	Findings	GQ3. Current evidence of interventions for improving safety practices and contributors to safety issues in nursing home settings This section provides an excellent and comprehensive summary of studies. Inclusion of the ROBIS score is very helpful.	Thank you for your comment.
141.	Peer reviewer #4	Findings	GQ4a. What is the uptake of evidence-based nursing home interventions beyond individual test sites? What are the most important barriers and facilitators to uptake of successful interventions? This section provides an integrated and balanced summary. The emphasis on implementation studies that examine care processes and nursing resources is appreciated.	Thank you for your comment.
142.	Peer reviewer #4	Findings	GQ4b. What major areas for future research remain regarding resident safety in nursing homes? This section identifies the major areas for future research in a very thoughtful manner.	Thank you for your comment.
143.	Peer reviewer #4	Findings	GQ4c. In what ways is the field of long-term care changing such that resident safety interventions may need to adapt to a new environment, and what additional challenges do these changing conditions bring to increasing long-term patient safety? This section provides clearly identified, appropriately integrated, and balanced content.	Thank you for your comment.
144.	Peer reviewer #4	Findings	GQ4c. To the extent that nursing homes choose to provide services for both short and long-stay residents within one facility, the impact of this dual focus on safety outcomes could be studied.	Again, this reviewer has identified an important modifier that should be assessed in future research.
145.	Peer reviewer #4	Findings	GQ4c. The efficacy and effectiveness of using medication aides who are specially trained to administer routine medications in the continuum of long-term care settings (board and care, assisted living, post-acute care) needs to be studied. With such limited nursing resources, there is a need to study how the nursing skill mix may be used in ways that are most strategic and effective in promoting quality and resident safety.	Future work informed by this Technical brief may address these kinds of issues. We call for more research into staffing models in section GQ4c and certainly that would encompass the type of assessment recommended by this reviewer.

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146.	Peer reviewer #4	Findings	GQ4c. Nursing homes need opportunities to innovate in ways that may not be consistent with surveyors' understanding of standards of practice. Study of interventions related to resident safety that challenge ubiquitous, non-evidence based, and time consuming practice standards is recommended.	This is an excellent point.
147.	Peer reviewer #4	Findings	GQ4c. The field of long-term care, including consumers, will have to deal with the economic consequences of valuing safety in the context of quality of life. Trade-offs may need to be made. Scope of practice and certification practices of various disciplines may need to be changed if we are to provide safe care. Consumer expectations may need to be modified by discussing the economic realities of providing long-term care. That is to say, the economics of providing resident safety in the nursing home need to be studied.	As we note in the report, there are tradeoffs between independence, quality of life and safety and we agree that this is a critical area for discussion in the field.
148.	Peer reviewer #4	Findings	GQ4c. Technological interventions that enhance resident safety in ways that are less costly than human intervention need to be explored.	We would hope that future research would include both human and technological interventions.
149.	Peer reviewer #5	Findings	GQ1a Safety issues in nursing homes—They review the common format adverse events and recommended topics from experts to develop their list of safety issues in nursing homes. It would have been better to describe what the responsibilities are for a nursing home to determine what would be included in a safe environment: the nursing home is a home (safety to prevent falls and infections) assistance to minimize functional loss and proving help with daily activities, treatments for chronic conditions, prevention of pressure ulcers, etc., coordination of care with primary care and rehab and avoiding unnecessary hospitalizations and emergency visits. The dichotomous list of contributing factors and adverse events does not sufficiently explain how some of the contributing factors relate to safety	We have revised the report to focus on areas that may contribute to safety in the nursing home as important areas for future research in refining our understanding of safety in this setting. Such future research could begin to better articulate linkages between contributing events and safety outcomes.
150.	Peer reviewer #5	Findings	GQ1a Why is dementia not on the list? What about behavior problems? If they had a better definition and conceptualization of safety, they would have explained that omissions in care are determined by understanding what is preventable or appropriate care given current technologies. That would then suggest that omissions and safety are only defined relative to current technology and a standard that may also define high quality care.	While we do agree, we also recognize that given a lack of accepted definition for nursing home safety, no particular set of events is universally accepted as the "right" set. This should be a fundamental part of the next steps in nursing home safety research.
151.	Peer reviewer #5	Findings	GQ1a They do not explain how patient centered care relates to safety but assert that it has some possible impact that is unsubstantiated. This section is weak because it does not have a good conceptual foundation and as a result misses important areas and includes items that are not clearly related to safety.	We have reorganized the report to discuss patient-centered care as an area for future research and made it clear that the question of whether or how it relates to safety should be a basis for future studies.

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152.	Peer reviewer #5	Findings	GQ1a The discussion of patient-centered care is similarly uninformative as to how patient centered care relates to safety, other than the possibility that it facilitates a safe environment. This is not clear because residents may want to move around more on their own when in fact this may increase the risk of falling, for example. Therefore, patient-centered care and safety may conflict.	We have reorganized the report to discuss patient-centered care as an area for future research. We note the potential trade-offs between greater autonomy and safety issues.
153.	Peer reviewer #5	Findings	GQ1b—differences for short and long stay—I do not think they have made a case that transitions are different for these two groups. They assert incorrectly that short stay have more transitions. Long stay residents who are there for a long time end up often in ED or hospitalizations for acute exacerbations of their conditions. They may have more medical than rehab related visits, but I would recommend removing this section.	The text currently reflects the reality that multiple types of transitions create vulnerability for safety issues.
154.	Peer reviewer #5	Findings	GQ1c—I think the focus on hospital interventions is not a fruitful exercise. In fact they conclude there is little information to find interventions worthy of trying in nursing homes. Why would you expect the interventions to work for a totally different population who are there for different reasons for a long time, for different type of care, etc. and in a setting with fewer skilled resources to adopt interventions that worked in hospitals? Also it diverts attention from the focus on nursing homes as they review the inadequately designed studies in hospitals.	To some degree we were constrained by the set of questions assigned as part of this contract. We further refined those questions with the help of our Task Order Officer and Key Informants and have organized the report as required. That said, the report is now substantially reorganized based on peer review comments and we believe it better addresses this reviewer's comments. We agree with this reviewer's point and tried to make that point in the brief. Nonetheless, there is an existing perception that hospital-based interventions can and should translate to the nursing home. As we note in the report, this is likely not a realistic or appropriate expectation.
155.	Peer reviewer #5	Findings	GQ1c—The discussion of falls is limited to the hospital and does not relate back to nursing homes.	We did not find evidence of falls interventions that were developed in the hospital being translated to the nursing home setting.

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156.	Peer reviewer #5	Findings	GQ1c—The discussion on pressure ulcers is insufficient. They should separate prevention from healing and both are relevant to both settings. What are the findings related to healing and what is known about prevention? In the discussion about infections they need to make the point that there are differences in care patterns. Nursing homes minimize the use of catheters so much that it is hard to place a hospitalized patient in a nursing home if they have a catheter.	One purpose of this report was to assess the potential applicability of hospital safety practices in the nursing home setting, which clearly constrained the ways in which we were able to address these issues. Certainly a great deal more could be said about each of the safety issues herein.
157.	Peer reviewer #5	Findings	GQ2- uniqueness in patients and nursing homes and effect on interventions—They highlight the differences in nursing homes reliance on unskilled staff. The review of reviews on number s of staff runs into the problem because the reviews do not include the more recent studies that fix some of the methodological issues related to selection and endogeneity. Grabowski and Konetska have both found stronger effects of staff amounts when making these methods issues are corrected. This is a risk of their methodology. The focus on reviews of staffing intervention studies only rather than individual studies gives an out of date conclusion on the evidence.	This is certainly a weakness of the methods; unfortunately, this topic area well exceeded the potential for doing a technical brief that addressed the primary literature.
158.	Peer reviewer #5	Findings	GQ3—Intervention evidence in nhs— The reviews of adverse events are inconsistent on whether they summarize findings from reviews or identify gaps	We find that the existing reviews do both and report what is available from the reviews. We have organized our presentation of tables for greater clarity. Tables that summarize review findings are now in an appendix.
159.	Peer reviewer #5	Findings	GQ3—a. Falls review is extensive but does not summarize well the findings.	The purpose of the Technical Brief is to outline where research exists vs. summarizing the findings of prior studies. We hope that the report lays out areas for additional research, including evidence syntheses.
160.	Peer reviewer #5	Findings	GQ3—b. Pressure ulcers-- Again the NPUAP guidelines would help summarize what is known and where the gaps are.	The purpose of the Technical Brief is to outline where research exists vs. summarizing the findings of prior studies. We hope that the report lays out areas for additional research.
161.	Peer reviewer #5	Findings	GQ3—c. Infection--Summary of findings is needed. d. Medication errors/polypharmacy—Review is not very informative. They focus on rigor more than substance. I thought a technical brief would focus more on substance and less on rigor.	We note that the purpose of the Technical Brief is to outline where research exists vs. summarizing the findings of prior studies. We hope that the report lays out areas for additional research.

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162.	Peer reviewer #5	Findings	GQ3—d. Weight loss and hydration--Summary describes the hydration studies, but does not discuss findings	This section no longer appears in the brief.
163.	Peer reviewer #5	Findings	GQ3—e. ADLs—discussion should be reorganized so that studies related to rehab are separated from interventions that reduce decline in functioning for long stay residents	This section no longer appears in the brief.
164.	Peer reviewer #5	Findings	GQ3—f. incontinence—The findings are insufficiently summarized. They make the point that many of the successful interventions take more staff time than normally allocated to incontinence care suggesting a barrier.	This section no longer appears in the brief.
165.	Peer reviewer #5	Findings	GQ3—g. depression—This section actually includes behavioral problems as well. This is a problem. Behavioral problems are mainly related to dementia and are separate from depression and anxiety issues typically. This would have been avoided if they had included dementia in their list. This section should be separated and behavior problems put in a dementia section. Nursing homes cannot prevent Alzheimer's disease with current technologies but they can prevent some behavior problems.	We have targeted the report extensively and this information no longer appears
166.	Peer reviewer #5	Findings	GQ3—h. Inappropriate use of psychotropic drugs--There is not enough of a findings summary, mainly just what was reviewed.	This section no longer appears in the brief.
167.	Peer reviewer #5	Findings	GQ3—i. The sections on pain, influenza vaccine and pneumococcal vaccine should be removed and just say insufficient information available.	This section no longer appears in the brief.
168.	Peer reviewer #5	Findings	GQ3—j. The other reviews section is not very useful. I would put the special care units discussion in with the new dementia /behavioral problems section that will hopefully be added.	This section no longer appears in the brief.
169.	Peer reviewer #5	Findings	GQ3—The review of coordinated care interventions should be separated as well. It gets lost here and should be somehow included with a discussion about coordinated care or the lack of coordinated care between nursing, rehab, and primary care in nursing homes. Earlier I discussed this as a major omission in the particular problems in nursing homes discussion.	This section no longer appears in the brief.
170.	Peer reviewer #5	Findings	GQ4a. This question has two parts evidence of uptake and important barriers. the first question is not part of the review and there is not basis for answering it. I do not believe the literature is good enough to answer it. There attempt to answer it is not specific to nursing homes. They are only speculating here. they make points about the need for consensus on what level of outcomes are considered preventable and what resources are needed. The common practice of ordering facilities on a quality measure is not central to this paper's discussion and is another example of lack of focus of this paper. Also it is not clear who the audience is for their response.	The methods of a technical brief involve relying on expert information from key informants, unpublished information and not only the literature. Therefore, we had hoped to answer this question with alternate approaches.

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171.	Peer reviewer #5	Findings	GQ4b-- 1.The areas in which they recommend a focus in the future do not come out of any framework or reflect any gaps that are identified in the review.	The literature review is only one component of this document and is not the basis for all aspects of the future research. We also included the input of our key informants, as is appropriate for a technical brief.
172.	Peer reviewer #5	Findings	GQ4b 2.They never make it clear what they mean by implementation science. It seems they mean studies that assess the resource needs of the intervention, but this is not a standard definition. They also talk about understanding which patients are most affected by the intervention, but this is not a topic of implementation science per se.	Implementation science is a broad area that does, as the reviewer notes, include providing data on resource needs for implementation, but more importantly that describes and studies the process of implementation. This type of research can provide critical insights into whether and how interventions can best succeed.
173.	Peer reviewer #5	Findings	GQ4b 3.The monitoring of performance is a new area that is not mention prior to the recommendations and reflects a concern that studies based on self report may have a lot of measurement error. This does not seem to be an appropriate topic for this paper. It is again an issue that is not specific to nursing homes.	Certainly this issue is not specific ONLY to nursing homes, but given the degree to which the current research base relies on self-reported data, we do think it is important.
174.	Peer reviewer #5	Findings	GQ4b 4.The discussion is of staffing models is unclear and results from using implementation science a term that they do not explain sufficiently. They also use the term staffing model but the discussion is very confusing and unclear. The focus on staff time is not justified compared to studies about the use of that time. What should staff be doing ? How should they be communicating with each other?,How can they best identify residents in need of more care? . What are the appropriate interventions?	The report is now substantially revised and we hope it better meets the reviewer's expectations.
175.	Peer reviewer #5	Findings	GQ4b 5.Discussion of optimal staff training is very unfocused and as with other foci recommended in this section, not part of the review they have done.	We have revised the report to discuss staffing more extensively as an area for future research.
176.	Peer reviewer #5	Findings	GQ4b 6. Point of care documentation systems is introduced here but left unexplained.	Unfortunately, we cannot expand on every point in the brief given the limitations on methods and length.
177.	Peer reviewer #5	Findings	GQ4b 7. They want to increase evaluation of person-centered care but its not clear why. The term is not well defined and they have not shown how it relates to safety as it is a very different but possibly overlapping concept. The questions they pose do not focus directly on safety.	We have moved this discussion and made it more clear why we believe it is important.

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178.	Peer reviewer #5	Findings	GQ4b 8.Another recommendation is to improve research on polypharmacy to reduce the number of meds prescribed. they have reviewed safety outcomes and polypharmacy in this document but they want to further study management of it with the hope, I suppose, that it will reduce adverse events. is polypharmacy a major contributer? Why pick this as an important focus. They don't make the case. The discussion has little to do with nursing homes.	This is one of many areas that warrant future research and we do not think we have placed undue emphasis on this area.
179.	Peer reviewer #5	Findings	GQ4b 9. Again they recommend using hospital experience with interventions to guide nursing ho safety research, although the evidenc e that it will help , they conclude in this study is very weak. This is unlikely to be a fruitful pursuit.	In fact, this is not the recommendation we make. We were asked to assess the degree to which lessons learned in hospital research translate to the nursing home and as we note, we do not think this is an appropriate assumption based on the available evidence.
180.	Peer reviewer #5	Findings	GQ4c--When describing the changes in long term care they missed totally the increase in post-acute care in nursing hmes and the movement away from cost based reimbursement to prospective risk based payments in which facilities take the risk of improving outcomes of residents to a particular level. They believe that as residents become more complex this will lead to more palliative care in nursing homes, but it may do the opposite with nursing homes needing to increase technology to meet the needs of their residents.	Certainly the move toward APMs, particularly episodes of care, will affect long term care substantially, but we are not in a position to speculate on what is likely to happen at this time.
181.	Peer reviewer #5	Findings	GQ4c They make a good point that as ALF increases it will be in important to monitor the quality of these facilities and assure that facilities are proving a safe environment. More data bout safety in ALF will be necessary.	Thank you for your comment.

#	Commentator & Affiliation	Section	Comment	Response
182.	Public reviewer #1 (Association for Professionals in Infection Control and Epidemiology)	Findings	We note that the Draft Technical Brief has identified catheter-associated urinary tract infections (CAUTI) as the most avoidable type of healthcare-associated infection. CAUTI is a significant cause of healthcare-associated morbidity. APIC is extremely concerned about the suggestion of antimicrobial prophylaxis as a means to reduce CAUTI in this population. The study cited for this suggestion was a meta-analysis on short-term use in mostly surgical patients and did not provide any evidence for antimicrobial use in the nursing home setting. The authors themselves state, "Additional studies should examine medical patients, including those living in long term care facilities, who might be catheterized for longer." Furthermore, the inappropriate use of antibiotics can put these nursing home patients at an increased risk for resistant organisms, Clostridium difficile, as well as adverse drug reactions. We would suggest instead that the focus in this population be directed toward avoiding the use of urinary catheters as much as possible, using them only for short periods, and only when clinically needed.	This section of the report has been substantially revised and we believe we have addressed these concerns.
183.	Public reviewer #1 (Association for Professionals in Infection Control and Epidemiology)	Findings	The Technical Brief also states, "In addition to using aseptic catheter placement and maintenance, the use of silver-alloy catheters has also been recommended and has been shown to reduce CAUTIs, at least compared to the usage of uncoated catheters." However, a recent meta-analysis demonstrated that silver-alloy catheters had no impact on symptomatic UTIs. Furthermore, the 2014 Compendium of Strategies for Prevention of Catheter-Associated Urinary Tract Infections states "Do not routinely use antimicrobial/antiseptic-impregnated catheters (quality of evidence: I)." Since the statement regarding the use of silver-alloy catheters is not consistent with recent evidence-based guidelines representing multiple professional societies, APIC suggests that AHRQ consider removing the reference to these catheters.	We have eliminated the text on silver alloy catheters.
184.	Public reviewer #1 (Association for Professionals in Infection Control and Epidemiology)	Findings	In the study referenced in the Draft Technical Brief, it was noted that specific MRSA-focused infection prevention and control activities did not reduce the prevalence of MRSA in nursing home residents. APIC supports the use of standard precautions, a group of infection prevention practices that apply to all patients, in any setting in which healthcare is delivered. These practices include hand hygiene, the use of personal protective equipment when there is a risk of body fluid exposure, safe injection practices, and the cleaning of both the patient environment and patient equipment.	We have added information about hand hygiene and infection control practices to the report.

#	Commentator & Affiliation	Section	Comment	Response
185.	Public reviewer #1 (Association for Professionals in Infection Control and Epidemiology)	Findings	The Draft Technical Brief did not find strong evidence for influenza immunization in healthcare workers who care for people 60 or older in long-term care. However, influenza immunization is recommended for everyone 6 months and older without contraindications and its use can decrease lost work time for healthcare workers as well as potentially protect patients. It should also be noted that although AHRQ did not find studies on outcomes and the use of pneumococcal vaccine, this practice is also recommended for use in this population.	Thank you for your comment.
186.	Public reviewer #2 (Lynne Bashton- Society for Healthcare Epidemiology of America)	Findings	On page 16 of the report under Infection the report cites antibiotic prophylaxis as an effective approach to decreasing the risk of CAUTIs in hospitalized patients undergoing shortterm usage of catheters. This recommendation is based on a metaanalysis of shortterm use in mostly surgical patients. In the context of this section it appears that antibiotic prophylaxis is being recommended as a possible approach for preventing CAUTIs among the nursing home population. SHEA recommends removing this suggested approach from the draft report as the cited metaanalysis did not include evidence for antimicrobial use in the nursing home setting. Inappropriate use of antibiotics places nursing home residents at risk of adverse drug reactions and developing multidrug resistant organism infections including Clostridium difficile infection. The report should instead focus on recommendations for limiting the use of catheters for nursing home residents and optimizing catheter care practices for those who do require catheters	We agree and have eliminated this text.

#	Commentator & Affiliation	Section	Comment	Response
187.	Public reviewer #2 (Lynne Bashton- Society for Healthcare Epidemiology of America)	Findings	Also on page 16 the report recommends the use of silver alloy catheters as a means for reducing CAUTIs. SHEA suggests removing this recommendation. A recent metaanalysis reports the use of silveralloy catheters had no impact on symptomatic UTIs. Lam TBL Omar MI Fisher E Gillies K MacLennan S. Types of indwelling urethral catheters for shortterm catheterisation in hospitalised adults. Cochrane Database of Systematic Reviews 2014 Issue 9. Art. No. CD004013. DOI 10.100214651858.CD004013.pub4. Accessed 11182105.. The 2014 Compendium of Strategies for Prevention of CatheterAssociated Urinary Tract Infections states Do not routinely use antimicrobialantisepticimpregnated catheters quality of evidence I. Lo E Nicolle LE Coffin SE et al. Strategies to Prevent CatheterAssociated Urinary Tract Infections in Acute Care Hospitals 2014 Update. Infection Control Hospital Epidemiology 2014350546479..	We have eliminated the text on silver alloy catheters.

#	Commentator & Affiliation	Section	Comment	Response
188.	Public reviewer #2 (Lynne Bashton- Society for Healthcare Epidemiology of America)	Findings	On page 17 of the report the following statement is included under the Policy Impact section Some recent data suggest that trends showing increasing CAUTIs are reversing and the increase in CAUTI is contrary to clearly evidenced reductions in other infections including central line associated bloodstream infections and hospital onset Methicillinresistant Staphylococcus aureus MRSA and C. difficile infections none of which would be as relevant to the longterm care setting. Although there is significant variability in the burden of C. difficile in longterm care facilities as well as reasonable debate about the location where acquisition has occurred including a statement proposing that C. difficile is less relevant in the longterm care setting would be an inaccurate statement. There is substantial data that suggest C. difficile is a significant problem in longterm care settings. The Centers for Disease Control and Prevention CDC published a report in 2014 estimating the burden of C. difficile infections none of which would be as relevant to the longterm care setting. Centers for Disease Control and Prevention CDC published a report in 2014 estimating the burden of C. difficile in hospitals other healthcare settings and the community. A study conducted in Ohio in 2008 showed that healthcarefacility onset C. difficile was more frequent in longterm care facilities than hospitals. Campbell RJ Giljahn L Machesky K CibulskasWhite K Lane LM Porter K Paulson JO Smith FW McDonald LC. Infect Control Hosp Epidemiol. 2009 Jun30652633. doi 10.1086597507.	We have revised this text to note applicability to the nursing home.
189.	Public reviewer #2 (Lynne Bashton- Society for Healthcare Epidemiology of America)	Findings	It is important to note that older adults who develop C. difficile and are discharged to or residing in nursing facilities are at greatest risk for recurrent disease Jump RL and Donskey CJ. Clostridium difficile in the LongTerm Care Facility Prevention and Management. Current Geriatrics Reports. 2015 Mar416069. PMID 25685657. PMC 4322371. Available on 20160301..	Thank you for this information.

#	Commentator & Affiliation	Section	Comment	Response
190.	Public reviewer #2 (Lynne Bashton- Society for Healthcare Epidemiology of America)	Findings	Similarly several studies have demonstrated that the prevalence of MRSA can be quite high among residents of longterm care facilities. For example a study conducted in 20032004 in 14 facilities in Michigan found that 40 of residents were colonized with MRSA.Mody L Kauffman CA Donabedian S Zervos M Bradley SF. Epidemiology of Staphylococcus aureus colonization in nursing home residents. Clin Infect Dis 200846136873 Another study that was conducted in three Veterans Affairs VA longterm care facilities in 20062007 found that the prevalence of MRSA among residents was 58 and that 10 of residents who were originally culturenegative acquired MRSA over a 6month period.Stone ND Lewis DR Johnson TM et al. Methicillinresistant Staphylococcus aureus MRSA nasal carriage in residents of Veterans Affairs longterm care facilities role of antimicrobial exposure and MRSA acquisition. Infect Control Hosp Epidemiol 2012335517 A subsequent study in 138 VA LTCF conducted between 2009 and 2012 reported an initial MRSA infection rate of 0.25 per 1000 residentdays. The infection rate decreased by 36 in association with the implementation of a multifaceted MRSA prevention initiative. Evans ME Kralovic SM Simbartl LA et al. Nationwide reduction in health careassociated methicillinresistant Staphylococcus aureus infections in Veterans Affairs longterm care facilities. Am J Infect Control 201442602 These studies suggest that MRSA is relevant to longterm care facilities and that interventions may reduce the risk of MRSA among residents of these facilities.	Thank you for this information.
191.	Public reviewer #2 (Lynne Bashton- Society for Healthcare Epidemiology of America)	Findings	SHEA notes that the report does not document recommendations for influenza immunizations in healthcare workers who care for longterm care residents. Influenza immunization is recommended for everyone 6 months and older without contraindications and its use can decrease lost work from for healthcare workers as well as potentially protect patients. Prevention and Control of Influenza with Vaccines Recommendations of the Advisory Committee on Immunization Practices United States 201516 Influenza Season. MMWR 20156430818825..	Thank you for this information. The purpose of this report was not to identify recommendations.

#	Commentator & Affiliation	Section	Comment	Response
192.	Public reviewer #2 (Lynne Bashton- Society for Healthcare Epidemiology of America)	Findings	Although AHRQ did not find studies on outcomes and the use of pneumococcal vaccine this practice is also recommended for use in this population Kobayashi M et al. Intervals between PCV13 and PPSV23 vaccines recommendations of the Advisory Committee on Immunization Practices ACIP. MMWR 201564349447..	Thank you for your comment.

#	Commentator & Affiliation	Section	Comment	Response
193.	Public reviewer#3 (Suicide Prevention Resource Center)	Findings	The Suicide Prevention Resource Center (SPRC) is pleased to submit the attached literature search as comment addressing questions GQ1a, "What are the safety issues of particular concern in the nursing home setting?" and GQ4b, "What major areas for future research remain regarding resident safety in nursing homes?". The search was requested by Jane L. Pearson, Ph.D., Chair, Suicide Research Consortium, National Institute of Mental Health in order that the significant issue of suicide be recognized as a priority concern for nursing homes and included in future research: The prevalence of suicidal behavior in VA nursing homes and long-term care (LTC) facilities has been estimated to be 1% (Mills et al., 2015). Approximately between 1% and 11% of all completed suicides in older adults occur in nursing homes (Reiss & Tishler, 2008a). According to a review of New York City cases between1990 and 2005, suicide risk in community-dwelling older adults declined over 15 years but remained unchanged in LTC facilities (Mezuk et al., 2008). The nursing home environment, recent or anticipated placement (Mezuk, et al.,2015), mental illness, functional impairment and physical illness, loss of independence and other recent exposure to stressful life events are risk factors for suicide, attempts and ideation (Reiss & Tishler, 2008a; Scocco, de Girolamo & Luigi, 2006). Similarly, internal locus of control and self-efficacy can be protective against suicide, attempts and ideation (Malfent, et al., 2010). Correlates of suicidal thoughts among long-term care residents include depression (Suominen, 2003), social isolation, loneliness, and functional decline (Mezuk et al., 2014; O'Riley, 2013; Ron, 2004). Because the nursing home environment has built-in safeguards that make it difficult to obtain means of suicide, such as guns, pills and ropes (Scocco, de Girolamo & Luigi, 2006; Menghini, & Evans, 2000), residents may employ indirect self-destructive behavior such as refusing to eat, refusing to take medications, refusing to get out of bed, drinking excessively, delaying or refusing treatment of medical conditions, and taking unnecessary risks (Reiss & Tishler, 2008b). Even with those inherent safeguards, one Italian study found that nursing home residents were not protected from risk (Scocco, 2006). In a review of 109 suicides in nursing homes and assisted-living facilities, nursing homes where a suicide took place surprisingly had significantly better overall quality rating scores (Jancin, 2014, reviewing Mezuk). While among non-nursing home residents more males die by suicide than females, among nursing home residents as many or more women may die by suicide (Reiss & Tishler, 2008a).	Thank you for this extensive information. Unfortunately we could not include many important topics, given the limitations of the technical brief format. We agree that this is a very important topic and one that warrants concern.

#	Commentator & Affiliation	Section	Comment	Response
194.	Public reviewer#3 (Suicide Prevention Resource Center)	Findings	In a study of root cause analyses, reports of suicides and attempts among men in Veterans Affairs LTCs, the primary mental health diagnoses were depression, posttraumatic stress disorder, and schizophrenia and the primary means of self-harm were cutting with a sharp object, overdose, and strangulation (Mills et al., 2015). Suicide risk remains elevated following discharge from nursing homes in the Veterans Affairs health system (McCarthy et al., 2013). Other common means of suicide among nursing home and LTC residents are falls from height (jumping) (Mezuk et al., 2008; Torresani,et al., 2014), hanging and medication overdose (Murphy et al.,2015; Menghini & Evans, 2000). In a survey of Italian nursing home residents, suicidal ideation appeared to increase with age (Scocco et al., 2009). [Additional citations provided]	Thank you for this extensive information. Unfortunately we could not include many important topics, given the limitations of the technical brief format. We agree that this is a very important topic and one that warrants concern.
195.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	GQ3. b. There are virtually no intervention studies that examined effectiveness of specialized staff training programs on psychosocial prevention of resident-to-resident altercations in the context of dementia in nursing homes and assisted living residences (except for the study published by Prof. Jeanne Teresi, cited above).	Thank you for your comment.
196.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	GQ4b. Studies on injuries and deaths subsequent to injuries as a result of resident-to-resident altercations are sorely needed. To my knowledge, the only study that examined physical injuries of nursing home residents due to resident-to-resident altercations was conducted by Shinoda-Tagawa et al. 2004. Virtually no study has examined deaths as a result of this type of adverse events (as reported in my Editorial to JAMDA which reviews the circumstances surrounding 40 deaths of older adults in the context of dementia; see citation above).	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.
197.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	Page 7. “Safety events (also known as adverse events include):…” This is a good place to acknowledge the public health problem of resident-to-resident altercations in general and in the context of dementia and serious mental illness in LTC home.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.

#	Commentator & Affiliation	Section	Comment	Response
198.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	Page 9. Falls with Injury. My aforementioned Editorial to JAMDA) (reviewing 40 deaths of older adults as a result of resident-to-resident altercations in the context of dementia) has shown that 13 of the 40 fatal altercations (32%) were "push/beat-fall" episodes (i.e., the push or beating caused the target residents to fall and hit their head or hip on the floor). Please consider acknowledging this underreported problem in your report.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.
199.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	While a large number of episodes of serious resident-to-resident altercations in dementia result in use of psychotropic medications and physical restraints (two of the important safety-related issues reviewed in your report), there is an urgent need to explicitly acknowledge the fact that numerous physical injuries occur during these episodes. This, as was found in the groundbreaking study by Shinoda-Tagawa et al. (2004) in Massachusetts' nursing homes: Shinoda-Tagawa T, Leonard R, Pontikas J, McDonough JE, Allen D, Dreyer PI. Resident-to-resident violent incidents in nursing homes. *Journal of the American Medical Association*. 2004;291(5):591-598.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.
200.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	Falls prevention. Every fall prevention programs in LTC homes needs to include a component on prevention of resident-to-resident altercations (i.e. "push-fall" episodes) because a large number of falls and injuries occur during these episodes.	Thank you for your comment.
201.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	Page 18. Staffing. Lack of adequate (well-trained) staff supervision of residents with dementia is commonly reported as a major contributing factor for physical altercations between residents in nursing homes. A pilot study by Bharucha et al. (2008) using video cameras in public spaces of LTC home for people with dementia has found that close to 40% of the episodes were not witnessed by staff. My Editorial in JAMDA shows that the majority of fatal episodes of resident-to-resident altercations (for which there were reports available to determine it) were not witnessed by staff. In addition, the majority of the fatal episodes took place inside bedrooms.	Thank you for your comment.

#	Commentator & Affiliation	Section	Comment	Response
202.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	Page 18. A very important sentence in your report is: "…problems occur and may be associated with…turnover, training, and educational level of staff." Beyond other critical areas requiring high-quality staff training, the vast majority of nursing home and assisted living staff do not receive training in preventing and de-escalating resident-to-resident altercations in dementia and serious mental illness. This major training gap not only puts older residents at risk of injury but also staff members who often courageously attempt to intervene and protect residents from others.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.
203.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	Number of staff. There is an urgent need to conduct studies that will examine the link between staffing levels and incidence and severity of resident-to-resident altercations in dementia and serious mental illness. Preliminary findings from the recent study by Prof. Mark Lachs and Pillemer, and Jeanne Teresi in 10 nursing homes should be acknowledged as a first step towards establishing this link.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.
204.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	Page 42. Overuse or Inappropriate Use of Antipsychotic Medications. Consider replacing the term "psychiatric symptoms" (page 42) and "behavioral problems" (page 47) in people with dementia with "behavioral expressions." Please see my publication for explanation (the need to shift from using biomedical and labeling terms to person-directed care terms): Caspi, E. (2013). Time for change: Persons with dementia and "behavioral expressions," not "behavior symptoms." *Journal of the American Medical Directors Association, 14(10),* 768-769.	Thank you. The issue of what language to use around many of these issues should be a part of the future research taken up by experts in this field.
205.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	Page 47. Consider avoiding the term "challenging behaviors" in nursing home residents with dementia. As explained by an experienced and insightful director of recreation therapies in my study: *"I don't like the words difficult behaviors or even challenging behaviors. If you imply that it's difficult or challenging, you are already putting a stigma on the person...and you don't want to work with them. It's like someone is saying: 'They are having a very challenging behavior' ...immediately, what do you feel? You feel that a brick wall comes up. Okay, I am ready for their challenging behavior. Everyone has behaviors...good and bad...whether we are with it or not with it...so why already classify them as difficult or challenging? You are not giving them a chance."* Citation: Caspi, E. (2015). Aggressive behaviors between residents with dementia in an assisted living residence. *Dementia: The International Journal of Social Research and Practice, 14(4),* 528-546.	We have considered this and decided to leave the text as is.

#	Commentator & Affiliation	Section	Comment	Response
206.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	GQ4b. What major areas for future research remain regarding resident safety in nursing homes? "Ultimately, the field should coalesce around specific safety measures in LTC,…" (Page 52). As noted above, the lack of questions in the MDS 3.0 that enable to differentiate the target of aggressive behaviors (i.e. those directed towards staff members versus towards other residents) needs to be resolved with a thoughtful and careful consideration of new questions (based on recommendations from and consensus of an expert panel) that would then be tested and added to enable to make this distinction. This, in turn could open the way for sorely needed studies on resident-to-resident altercations in dementia and serious mental illness in NHs (using MDS and other datasets that could be linked to MDS data). Please see detail in my Letter to the Editor of JAMDA (cited above). Also, the first instrument for measuring resident-to-resident altercations has recently been published by Prof. Jeanne Teresi and colleagues: Teresi et al. Development of an instrument to measure staff-reported resident-to-resident elder mistreatment (R-REM) using item response theory and other latent variable models. *The Gerontologist*. 2014;54(3):460-472. This new evidence-based measure represents a precious opportunity to conduct studies using a measure that was developed and evaluated with a large smaple of NH residents in several NHs.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.
207.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	p. 53. "What are the staff-time requirements associated with interventions known to prevent adverse events?" See critically important findings from a study in VA LTC homes by Souder & O'Sullivan (2003). Disruptive behaviors of older adults in an institutional setting: Staff time required to manage disruptions. *Journal of Gerontological Nursing, 29(8),* 31-36.	Thank you for pointing out this reference. The paper may serve to inform future reviews or other work that may begin to address this issue.
208.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	Similar study needs to be conducted to identify staff time requires to address resident-to-resident altercations in dementia and serious mental ilnness in NHs and assisted living residences (while the aforementioned study did report on several behavioral expressions labeled "aggressive," the study did not report on whether the behaviors were directed towards staff or towards other residents).	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.

#	Commentator & Affiliation	Section	Comment	Response
209.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	Assistive technology. In light of persisting challenges in staff supervision of residents with dementia and serious mental illness, there is an urgent need to develop assistive technologies that would generate a signal to staff in real time when an altercation b/w residents is about to take place or when it has already developed. Vigial Dementia System is one example (that needs to be evaluated in research) but it is limited to entry and exit of residents into and from their and other residents' bedrooms. A recent collaboration between Dementia Behavior Consulting LLC (my company) and Orfield Labs Inc. (Steve Orfield) is working on development of an assistive technology that will enable to generate an alert in real time to staff in all spaces (public and private) of the LTC home (we will soon have a proposal ready for submission for funding and would love to hear whether AHRQ may have funding opportunities for this purpose). Please email me at eiloncaspi@gmail.com if you do know about such funding mechanisms.	Thank you for your comment.
210.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	"…use of standard observation tools by managers…" See my aforementioned unpublished manuscript (entitled "Rigor versus Relevance…") on limitations inherent in the majority of instruments designed to capture behavioral expressions in LTC residents with dementia. You are welcome to contact me for detail about practical tools that are sensitive to the circumstances and sequence of events leading up to episodes of resident-to-resident altercations (the key for effective prevention and risk management efforts). These tools will soon be published in my book on prevention of resident-to-resident altercations in dementia in LTC homes (expected release by mid 2016 with Health Professions Press).	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.
211.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Findings	p. 56. "Assisted Living Facilities" (ALFs). "With only a few studies examining ALF care quality." Please consider adding my study (the first to examine resident-to-resident altercations in assisted living dedicated solely for people with dementia): Caspi, E. (2015). Aggressive behaviors between residents with dementia in an assisted living residence. *Dementia: The International Journal of Social Research and Practice, 14(4),* 528-546.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.
212.	Peer reviewer #1	General	This report does not have a clear focus. It is presumably about interventions. The inclusion of many areas seems unjustified. It might have been more useful to concentrate on fewer areas better.	We have revised the report substantially to clarify its focus on setting a research agenda to explore safety issues in the nursing home context. In addition, we have focused most of the report on the four elements of AHRQ's "Common Format" for reporting safety issues in nursing homes.

Source: https://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=2224
Published Online: May 27, 2016

#	Commentator & Affiliation	Section	Comment	Response
213.	Peer reviewer #2	General	General Comments: The report is well written and thorough.	Thank you for your comment.
214.	Peer reviewer #2	General	Conceptually I recommend clearly separating studies on primary safety outcomes such as falls and pressure ulcers from studies on potential contributing factors, such as depression and urinary incontinence.	The report now focuses on primary safety issues; potential contributing factors are described as areas for possible future research.
215.	Peer reviewer #2	General	I do not understand why studies of potentially preventable hospital transfers are not included as I thought they are considered an important patient safety complication.	We focused on the 4 safety events as currently identified in the PSOPPC Common Formats for Event Reporting on Nursing Home Safety Version 0.1 Beta. We also recommend that additional parameters that reflect important concerns in the nursing home setting be considered in defining safety in this setting. Mitigating those additional issues (Table 8 in the revised report) may help to prevent hospitalizations.
216.	Peer reviewer #3	General	General Comments: Overall, this is a well done and important technical brief that is desperately needed. There is a paucity of information to help those who are interested in improving safety in nursing homes. This report builds upon the fund of knowledge and should help researchers, those who develop and enforce policy, and clinicians advance safety science.	Thank you for your comment.
217.	Peer reviewer #4	General	General Comments: Overall, this is a comprehensive description of the state of the science. The tables are excellent	Thank you for your comment.
218.	Peer reviewer #4	General	The only types of adverse events that where not included, and may have been, were resident abuse and elopement.	We agree that these are important adverse events; however, they did not fall within the framework we outlined in GQ1a.
219.	Peer reviewer #4	General	I did not find that there was a potential framework presented to understand resident safety from both a technical and interpersonal perspective. Overall, the focus seemed to be primarily the impact of the intervention on the resident. I understand this. But in nursing homes, at this time, resident safety depends in great measure on the behaviors of staff members. Future studies need to include this perspective and consider the benefits of using rigorous qualitative methods.	We have noted that future research could include qualitative studies.

#	Commentator & Affiliation	Section	Comment	Response
220.	Peer reviewer #5	General	General Comments: This paper is too vague about what are safety practices and how they relate conceptually to quality of care, quality of life, and patient-centered care, and outcomes. Since the literature quoted is not necessarily focused on safety, but may be organized related to these other concepts, it is important to focus on safety and distinguish it from these other concepts. This is important because in some cases it needs to be clear that an intervention may improve quality of life but not affect safety, for example. Terms are used often interchangeably. The focus should be on adverse events.	We have targeted the report on safety issues identified in the Common Format and discuss the context of safety in the nursing home in the future research section.
221.	Peer reviewer #5	General	More attention needs to be given to the nursing home context of when something by definition reflects harm and when it is normal aging. I wanted a list of adverse events they would discuss and why these were chosen. This is done later but should be introduced here. Because this is not done well, the paper gets very confused at times. Instead they define safety but then do not make these important distinctions and then begin by describe deficiency data which is about quality of care not safety per se and perhaps quality of life. Later at times they discuss care quality when the focus is on harm.	We have reorganized the report to focus on the 4 PSOPPC Common Format safety events and to describe other parameters that may affect safety as areas for future research. Thus, safety events are defined as these four events early in the report. Later in the report, we describe why we believe these to be inadequate.
222.	Peer reviewer #5	General	The paper does not set the limitations well for being a Technical Brief and I sympathize because this is difficult given that it is a broad subject not just one intervention that is discussed.	We discussed the difficulties of approaching this broad topic in the technical brief format in the Technical Brief Objectives section and have added more information on the scope and focus of the report to the Background.
223.	Peer reviewer #5	General	The biggest issue is what they should do about evidence. What should be reviewed and what should be part of a true evidence report? This I do not think is successfully dealt with. Also they do not organize the studies well enough by section to include the relevant topics by adverse events.	This is a core challenge of the technical brief format for a large topic. The purview of the brief is only to describe the numbers and types of studies available, not to assess the evidence, which would be the purview of an evidence review.
224.	Peer reviewer #5	General	I think the goals of the paper were not clearly presented.	We have added more information on the scope and focus of the report to the Background section.
225.	Peer reviewer #5	General	When reviewing literature they do not focus on studies that relate directly to safety but treat all studies that treat outcomes quality of care etc as equally relevant and discuss them as if they are informing the safety literature.	We have targeted discussion of safety issues per se on the Common Format issues that have been determined by AHRQ to be clear safety issues and describe other potentially contributing events within the future research section of the brief.

#	Commentator & Affiliation	Section	Comment	Response
226.	Peer reviewer #5	General	Although the importance of post acute care is emphasized in the beginning it is not mentioned in the overview of changes in the environment. It is clearly growing and influencing how care is provided for both long and short stay residents.	We agree that post acute care is an important area for focus, but it is not within the scope of our newly targeted approach.
227.	Peer reviewer #5	General	They should include a discussion of coordination oaf care between nursing home staff, primary care and rehabilitation. This affects emergency use, hospitalizations and safety in the nursing home.	Again, this is beyond the scope of this brief.
228.	Peer reviewer #1	Guiding Questions	[Background/Report Organization] The inclusion of several topics is not well justified. The authors have chosen to address a large set of questions. Less may be more in this case.	We determined the KQ in conjunction with our TOO and with technical expert input. Stakeholders with whom we spoke felt these questions were important to address. That said, we have substantially refocused the report to review the science on a smaller set of clear safety issues as defined by the AHRQ Common Format. We hope that this will be clearer and more succinct and will address this reviewer's concerns.
229.	Peer reviewer #2	Guiding Questions	Guiding Questions: The guiding questions are on target	Thank you for your comment.
230.	Peer reviewer #3	Guiding Questions	Guiding Questions: The guiding questions are appropriate and seem complete given the goals of the technical brief and background.	Thank you for your comment.
231.	Peer reviewer #4	Guiding Questions	Guiding Questions: The guiding questions used to structure this technical brief are important and comprehensive for the most part. The foci of contextual characteristics recommended for study are structural measures of quality. I recommend the addition of research questions focused on specific management and leadership practices (e.g. work processes) associated with levels of safety culture or climate.	We cannot add guiding questions to the report at this phase, but we note that we have added discussion of management and leadership and their effects on safety in nursing homes to the future research section of the report.
232.	Peer reviewer #5	Guiding Questions	Guiding Questions: 1. The guiding questions are listed as if this is a paper about an intervention, rather than a review of safety in nursing homes. This creates a mismatch with the purpose of the paper. This should have been made clear in the introduction.	While we cannot revise the guiding questions at this point, we have targeted the report throughout to clarify its purpose.

#	Commentator & Affiliation	Section	Comment	Response
233.	Peer reviewer #5	Guiding Questions	2. I was concerned about the guiding question related to hospital interventions and continued to be when reading the entire document. At times the paper regresses into discussion of the limitations of methods in evaluating the hospital intervention and this regression occurs too often, losing the focus on nursing home resident safety. Nursing home residents are different from hospital residents-- the period of time they are there, the reasons they are there, and the populations are different. Therefore the skill mix of staff and r the resources are different. The transfer of interventions that worked in hospitals to nursing homes is not straight forward and deserved much less focus than it receives in the paper.	The guiding question on hospital interventions was assigned as part of the initial RFTO for this project. We share your concerns and tried to make clear throughout the report that to assume that hospital-based interventions can or should be simply translated to the nursing home setting misses the reality that nursing home residents are not simply longer term hospital residents and that there are many differences between these settings.
234.	Peer reviewer #5	Guiding Questions	3. Patient centered care is introduced in GQ1a, but it is not clear how it relates to safety per se. This is due to the poor conceptualization of safety in the beginning of the document. Pateint centered care often relates to preferences being considered and choice of basic life issues such as when to eat, sleep, etc. How this relates to harm and adverse events is not articulated well. It is not necessarily a potential contributing factor.	The conceptualization of safety is based on the AHRQ common format, which was a requirement of the project. We have moved patient-centered care to the future research section as it may be an approach that could underlie safety interventions and approaches to care that may reduce the likelihood of safety events. In particular, though, if it is to be raised as a safety issue (as it was by our key informants), we note that empirical research is needed to make that connection.
235.	Peer reviewer #5	Guiding Questions	4. The discussion of safety in nursing homes starts with why it is different from hospitals. This lead to a discussion which is obvious about how nursing homes are different from hospitals. They should start by looking at the scope of nursing homes care: that nursing homes are responsible for safety of living situation (falls matter, infection control), safety of care, safety of transitions, safety related to rehab for short stay, and safety in medication. Why start with the hospital? Why start with the common formats. Why not directly describe the safety issues for nursing homes?	To some degree we were constrained by the set of questions assigned as part of this contract. We further refined those questions with the help of our Task Order Officer and Key Informants and have organized the report as required. That said, the report is now substantially reorganized based on peer review comments and we believe it better addresses this reviewer's comments.
236.	Peer reviewer #5	Guiding Questions	GQ1b--Transitions are a problem for both short and long stay residents, so this distinction is not valid. The specifics may differ and long stay residents may have acute transfers to hospital and short stay may be transitioning in to nursing home for a short time for rehab.	We have revised the text for GQ1b to note that transitions may occur to and from multiple settings of care.
237.	Peer reviewer #5	Guiding Questions	GQ1b They describe differences in experience of short and long stay residents , but do not relate it to studying safety. This needs to be added.	We agree that this is an important point and needs to be studied. It should be a part of the future research.

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238.	Peer reviewer #5	Guiding Questions	GQ1c I think this is an area of discussion that should be minimized. The transfer of interventions to a totally different population and setting is just not realistic under most situations and the hospital intervention discussion results in too much discussion of hospital studies and loses the focus of the document. Not surprising they conclude that evidence for hospital safety ..."we could not ascertain that safety has improved for areas of most relevance to long-term care."	We agree and tried to make that point in the brief. Nonetheless, there is an existing perception that hospital-based interventions can and should translate to the nursing home. As we note in the report, this is likely not a realistic or appropriate expectation.
239.	Peer reviewer #5	Guiding Questions	GQ2a this section does not deal importantly with the coordination of care between nursing home staff and primary care and how it affects transitions, outcomes and safety outcomes. Also studies of staffing in reviews do not deal with the methods issues related to selection bias in studies. Therefore the conclusions they reach do not reflect the current literature. Recent papers by Konetska and by Grabowski that deal with selection issues using instrumental variable methods find stronger effects of staffing levels on safety.	Care coordination outside the nursing home was not within the scope of the current brief, but is obviously a very important topic and should continue to be addressed
240.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Guiding Questions	Page 6. GQ2. d. Consider: Residents with dementia and serious mental illness.	Thank you for this information. We have retained the original wording.
241.	Peer reviewer #1	Methods	[Background/Report Organization] 15, 10: GQ 4a: Why would there be uptake if evidence is weak?	Exactly the point – before we did the review we did not know that there would be only weak evidence. As we note, a significant barrier to uptake is the weak evidence for available interventions.
242.	Peer reviewer #1	Methods	[Background/Report Organization] 23: These two areas identified as potential strategies for intervention?	We have targeted the report extensively and this information no longer appears.
243.	Peer reviewer #1	Methods	[Background/Report Organization] 30: weight loss does not typically include dehydration	We have targeted the report extensively and this information no longer appears.
244.	Peer reviewer #1	Methods	[Background/Report Organization,] 35: How do vaccines get lumped in here?	We have targeted the report extensively and this information no longer appears.
245.	Peer reviewer #1	Methods	[Methods] 43: extant reviews etc.?	We have noted that we used published systematic reviews (vs. conducting a de novo review) and studies to address the Guiding Questions.

#	Commentator & Affiliation	Section	Comment	Response
246.	Peer reviewer #1	Methods	[Methods/Data Collection] 16, 35: What is the relevance of 1998?	We selected a search date to take into account literature published after the inception of NH Compare but that is more recent and likely reflects the state of care in the nursing home setting currently.
247.	Peer reviewer #1	Methods	Table 4, pg. 9: are depressive symptoms, pain, ADLs, and incontinence safety issues?	We have shortened the report extensively and this information no longer appears as a safety issue but a potential factor to consider for future research around the definition and limits of safety in the nursing home setting.
248.	Peer reviewer #1	Methods	[Methods/Quality Assessment] 17, 32: Do reviews have ROB? What about SOE?	The ROBIS tool we used to assess systematic reviews evaluates the rigor of the reviews' conduct. As this is a technical brief, we did not assess the strength of the evidence. We reported a general statement of conclusions from the reviews we assessed for GQ3 but did not comment specifically on SOE if the reviews assessed that.
249.	Peer reviewer #2	Methods	Methods: The Key Informant information is weak. Only 7 of 20 invitees participated.	We have added additional information about the Key Informants.
250.	Peer reviewer #2	Methods	In Table 4 why isn't unplanned potentially avoidable hospitalizations listed? Doesn't AHRQ consider this a patient safety issue?	We focused on the 4 safety events as currently identified in the PSOPPC Common Formats for Event Reporting on Nursing Home Safety Version 0.1 Beta. We also recommend that additional parameters that reflect important concerns in the nursing home setting be considered in defining safety in this setting. Mitigating those additional issues (Table 8 in the revised report) may help to prevent hospitalizations.
251.	Peer reviewer #2	Methods	In Table 4, outcomes are mixed with potentially contributing factors. I think they should be separated here and throughout the document	We have restructured our presentation of safety issues.

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252.	Peer reviewer #3	Methods	Methods: The interactions with the key informants seems concerning. A total of only 7 individuals agreed to participate. Moreover, it doesn't state what their professions where that participated, despite it stating that the pool included those from nursing home safety, hospital safety, quality of care, nursing home and assisted living administration, health services research, advocacy, policy, medication safety and risk management. It seems that at a minimum, the key informants credentials should be listed	KI names will be included in the front matter of the report but were redacted at the peer review stage. Due to OMB regulations, we are limited to the inclusion of no more than 9 individuals and of those we invited, only 7 agreed to participate. We agree that broader representation would be ideal.
253.	Peer reviewer #3	Methods	I was also concerned that some terms were being conflated. It is important to note that medication errors, polypharmacy, inappropriate medication use, are not always associated with patient harm or should be considered safety events per se. One way to clarify this is to simply remove the "(also known as adverse events)" section from the paragraph on page 7.	We have revised this section as noted.
254.	Peer reviewer #3	Methods	Also, it is important to note that the potentially contributing factors can sometimes not be avoided or are expected as a direct result of the disease state/condition and/or the care plan goals of a resident (e.g., ADL loss in a resident who is hospice and is actively dying).	We have revised our discussion of these factors and describe them in the future research section of the report.
255.	Peer reviewer #3	Methods	The literature review was very well done.	Thank you for your comment.
256.	Peer reviewer #4	Methods	Methods: This section clearly and concisely describes how data were gathered. The participation of Key Informants is well described.	Thank you for your comment.
257.	Peer reviewer #5	Methods	Methods: The methods section is straight forward.	Thank you for your comment.

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258.	Public reviewer #2 (Lynne Bashton- Society for Healthcare Epidemiology of America)	Methods	In addressing GQ3 Describe the current evidence of the intervention for safety practices in nursing home settings the Technical Brief is based solely on the findings of previously conducted systematic reviews. The authors indicate however that they identified 239 new comparative studies including 185 randomized controlled trials published since the included systematic reviews that were not included in the analysis page 50 Table 25. As the authors note this large number of new studies suggests the presence of a substantial research base. Ideally these studies would be included in the analysis to provide readers with an uptodate summary of the evidence for various nursing home safety interventions given the stated objective to provide the reader with an overview of available research practice and to some degree perspective around a given clinical intervention. If the findings from these studies are not included however it would be very useful to those readers who want to further explore these topics if the authors could provide a list of references for these 239 new studies.	The purpose of the Technical Brief is not to summarize the findings of the new studies but to provide of high level map of the evidence that exists. We have, however, provided an appendix of the citations identified as published after the publication of the systematic reviews described in the report.
259.	Peer reviewer #1	Next Steps	Pg. 57 Likewise, what are next steps? What is currently actionable? What requires more work?	We have revised this section to focus on the future research agenda.
260.	Peer reviewer #2	Next Steps	Next Steps: One thing I don't see explicitly mentioned is the physical structure of nursing homes. Providing person centered safe care in a more homelike environment is a real challenge. Studies that examine such environments would be valuable.	We have added a statement to the future research section to address this point.
261.	Peer reviewer #3	Next Steps	Next Steps: It would seem to me that we would want the authors to speculate and ask us to take a leap of faith as to how to advance the safety science. If we were to take the lessons learned in the hospitals, what would we want to take into the nursing home setting? I think that we do a disservice to state that we simply cannot afford EMRs, clinical decision support systems, or telemedicine. These will come when ACOs, bundled payments, value-based purchasing and other drivers provide the right incentives.	We have tried to balance the need to report on what exists with extrapolating appropriately. However, it would be out of our scope to engage in speculation at this time. We do hope that this brief can provide a basis for researchers to build a future research agenda that pushes the envelope more than we are able.
262.	Peer reviewer #4	Next Steps	Next Steps: This section is the weakest, in my opinion. It does not include specific recommendations, with the exception of better reporting of data sources used in studies.	We have revised the Next Steps section of the report and hope that it will better inform future research in this area.
263.	Peer reviewer #5	Next Steps	Next Steps: The discussion of next steps and the overall summary are inadequate.	We have revised and expanded this section.
264.	Peer reviewer #1	Summary and Implications	Pg. 57 Only very general statements here. Not really a summary	We have revised this section to focus on the future research agenda.

#	Commentator & Affiliation	Section	Comment	Response
265.	Peer reviewer #2	Summary and Implications	Summary and Implications: The summary and implications is clear and contains several good ideas.	Thank you for your comment.
266.	Peer reviewer #3	Summary and Implications	Summary and Implications: The summary and implications section did not in my opinion adequately state or summarize what the report's conclusions were. Rather it listed the report's limitations.	We have revised the summary section of the report and hope that it will better inform future research in this area.
267.	Peer reviewer #4	Summary and Implications	Summary and Implications: The summary identifies the practice settings that have not been addressed in this brief, although they are components of the post-acute care continuum. Little is mentioned about key decisional uncertainties or organizing conceptual frameworks.	We have reorganized the concluding sections of the report to describe research areas and implications more explicitly.
268.	Peer reviewer #4	Summary and Implications	I recommend that an analysis of the cost of an intervention as compared with usual practice is included in more studies.	We have noted that understanding of resource issues is an important gap in implementation research. This should include costs.
269.	Peer reviewer #4	Summary and Implications	As noted in the brief, resident safety is complex. Nursing home work is labor intensive and relationship based. It lends itself to the use of frameworks such as human factors, information exchange models, complexity science, social networking models, and use of mixed methods	We have attempted to point out the importance of the context of care in nursing homes and note that understanding safety issues broadly within this context is a key area for future research.
270.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Summary and Implications	"Several areas are notably missing in this report." Please acknowledge the prevalent, concerning, but under-recognized and understudied public health problem of resident-to-resident altercations in nursing homes and assisted living residences. A recent rigorous study in 10 NHs in NY by Prof. Lachs, Pillemer, Teresi and their colleagues has shown that this behavioral phenomenon is very common. Lachs M, Pillemer K, Teresi JA, et al. Resident-to-resident elder mistreatment: Findings from a large-scale prevalence study. Symposium. In: *The 67th Annual Scientific Meeting of the Gerontological Society of America*. Washington, DC; 2014. I also compiled evidence from at least dozen other studies that support these researchers' finding (will be glad to share it with you if you will be interested).	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.

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271.	Public reviewer#4 (Eilon Caspi, Dementia Behavior Consulting, LLC)	Summary and Implications	To my knowledge, research on Veteran-to-Veteran altercations in the context of dementia in Community Living Centers and State Veterans Homes is sorely lacking. This is a source of concern given the unique characteristics of Veterans(combat experience, frontal lobe injuries, TBIs, problems with impulse control and angry outbursts, PTSD, etc.) and VA LTC homes (vast majority of residents are male) which may put them at enhanced risk of engagement in this form of behaviors.	Thank you for your comment. We have noted this as an important area that was out of scope for the current report.