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RESPONSE TO LETTER

Factors Influencing the Implementation of Unaccompanied Care for Older Inpatients in Chinese Tertiary Hospitals: A Qualitative Study [Response to Letter]

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Dear editor

We sincerely thank Zhao et al[1] for their thoughtful Letter to the Editor and for the opportunity to respond. We appreciate their emphasis on methodological clarity, inclusive stakeholder representation, and ethical considerations. Below we address the main points raised.

Clarification of the Unaccompanied-Care Model Studied

We agree that "unaccompanied care" can refer to different service configurations. In our article,[2] we described two common forms in China to provide policy context. The implementation discussed by our participants centered on a nurse-supervised professional caregiving arrangement, delivered in collaboration with a companion-care company, in which trained nursing assistants provided daily-living assistance and basic bedside care while family members were not expected to provide routine caregiving.

We agree that future studies should report key operational parameters more explicitly (eg, task scope, staffing arrangements, and the nature of family presence for emotional support) and should compare perceptions across model types when more than one form is present, to strengthen interpretability and internal validity.

Stakeholder Representation and Care-Worker Perspectives

We fully agree that care workers are essential stakeholders. In our study,[2] stakeholders included not only nurses, nurse managers, physicians, and administrators, but also personnel from the companion-care company involved in service delivery (eg, the company manager and care-team leaders/nursing aides), whose roles include organizing care assignments, supervision, and training.

We welcome this recommendation and suggest it as a key direction for future qualitative work.

Enrollment Pathways and Dropout Perspectives

We appreciate the concern about enrollment mechanisms and potential selection bias. At the study site, unaccompanied care was offered as a pilot, optional service during hospitalization; patients and families were informed of the option during admission-related communication and participation was voluntary. Our purposive sampling aimed to capture varied experiences among those directly involved in the pilot implementation.

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We agree that perspectives from those who declined enrollment or discontinued the service may reveal important barriers and decision turning points. These groups were not included in our sample, which may introduce selection or survivorship bias. Future research should transparently document referral/entry pathways and incorporate interviews with decliners and dropouts to strengthen methodological rigor.

Disease-Specific Heterogeneity

We agree that diagnosis and clinical pathway may shape care needs and expectations under unaccompanied care. Our inclusion criteria focused on older inpatients with higher care needs to ensure relevance to the service, but we did not stratify analysis by disease type.[2] Future studies could adopt stratified sampling and conduct subgroup comparisons to identify condition-specific facilitators and barriers.

Privacy, Confidentiality, and Relational Boundaries

We appreciate the emphasis on privacy protection and relational boundaries in high-contact care. In the pilot program, care workers were required to comply with hospital confidentiality and conduct policies, and training emphasized respectful and safe care. However, we agree that privacy exposure and boundary management warrant more systematic exploration in future research.

Future studies should include privacy- and boundary-focused prompts to identify scenarios that elicit concerns, safeguards that foster trust, and training/governance mechanisms that support ethical and sustainable implementation.

In summary, we are grateful for the constructive comments from Zhao et al. We concur that future work should clarify operational definitions, broaden stakeholder inclusion, improve transparency regarding enrollment trajectories, and integrate ethical and privacy considerations. We hope this response is helpful to readers and contributes to ongoing development of person-centered unaccompanied-care services.

Disclosure

The authors declare no conflicts of interest in this communication.

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