PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Electronic risk assessment for venous thromboembolism: investigating physicians' rationale for bypassing clinical decision support recommendations
AUTHORS	Brooks, Hannah; Nwulu, Ugochi; Richardson, Suzanna; McFarland, Lorraine; Coleman, Jamie

VERSION 1 - REVIEW

REVIEWER	Prof Edward Janus Department of Medicine Western Health and University of Melbourne Australia
REVIEW RETURNED	27-Jul-2014

GENERAL COMMENTS	Consider as an alternative title "Why doctors bypass clinical decision support recommendations; using...." 1).Some additional background information is required to enable the reader to fully understand the paper. (a)The total number of VTE risk assessments expected (presumably similar or equivalent to patient throughput) and number performed during the 7 month study period in this 1200 bed facility.(b)the number performed and number not performed. c) the proportion where enoxaparin was not prescribed when recommended- 38% in 2010. What was it during the study period? (d) Both the number of free text responses provided and the number expected if we assume there was to be a response expected for each time enoxaparin was not prescibed when recommended. This will provide context and will give some idea if the 1136 resopnses are representative. 2).More details of the VTE risk assessment tool which could be in an appendix. More details of the sign off process and the extent to which this allows clinical reasons for non use of enoxaparin to be documented. Are there rules/prompts for which medical and surgical patients should/should not receive enoxaparin. Ultimately we want to know that those who need it get it at the correct dose and that thoise who dont need it or have contraindications dont get it. ie each patient is treated "appropriately" In the discussion its clearer if the opening sentence is "In a quarter of cases the system succceeded in...." The presentation of results and the accompanying discussion is clear. The aim is to determine how the system can be improved as its meant to provide "support" Most of thast has been discussed but the ways to support appropriate prescribing is not entirely clear .

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REVIEWER	Emma Gee King's College Hospital NHS Foundation Trust, England.
REVIEW RETURNED	28-Jul-2014

GENERAL COMMENTS	It is well written, relevant and useful in improving current practice.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1	
Consider as an alternative title "Why doctors bypass clinical decision support recommendations; using...."	We have altered the title as suggested by the editor and the reviewer. The new title is as follows: Electronic risk assessment for venous thromboembolism: investigating physicians' rationale for bypassing clinical decision support recommendations
1).Some additional background information is required to enable the reader to fully understand the paper. (a)The total number of VTE risk assessments expected (presumably similar or equivalent to patient throughput) and number performed during the 7 month study period in this 1200 bed facility.(b)the number performed and number not performed. c) the proportion where enoxaparin was not prescribed when recommended- 38% in 2010. What was it during the study period? (d) Both the number of free text responses provided and the number expected if we assume there was to be a response expected for each time enoxaparin was not prescribed when recommended.	The text has been updated and the following points are now discussed (see p. 6 paragraph 1; p. 7 paragraph 4; p. 13 paragraph 2) a) Over the 7 month study period, there were 37,737 admissions to the hospital. b) Over 99% (approx. 37,340) of admissions receive the VTE risk assessment within 24 hours of admission. c) 34.1% of enoxaparin was not prescribed where recommended in 2012-13 – this information has replaced the 2010 figures in the text. d) The number expected is approximately 12,740 and the number provided was 1,136. The main reason for which no free text response would have been provided is likely to be due to patients being discharged before 07:30am the following day (the time at which the alert is triggered if no enoxaparin is presently prescribed on the patient record) and thus the alert would not be triggered and no free text response would be made.
2).More details of the VTE risk assessment tool which could be in an appendix. More details of the sign off process and the extent to which this allows clinical reasons for non-use of enoxaparin to be documented. Are there rules/prompts for which medical and surgical patients should/should not receive enoxaparin. Ultimately we want to know that those who need it get it at the correct dose and that those who don't need it or have contraindications don't get it. i.e. each patient is treated "appropriately"	As stated in the text, when enoxaparin is not prescribed where recommended, a free text box is automatically provided and into which the clinician must provide a reason for their decision not to prescribe. The authors then coded these reasons for the purpose of this paper. We refer the reviewer to figures 1 and 2 for further details of the assessment tool and process for documenting clinical reasons for not prescribing enoxaparin. We have also included additional details about the VTE risk assessment process in an appendix (Appendix A).
In the discussion it's clearer if the opening sentence is "In a quarter of cases the system succeeded in...."	This has been amended
The presentation of results and the accompanying discussion is clear.	Thank you
The aim is to determine how the system can be improved as it's meant to provide "support" Most of that has been discussed but the ways to support appropriate prescribing is not entirely clear.	We agree with this comment and have included additional information to the final paragraph of the discussion in which we highlight the importance of system improvements to improve the process of prescribing and prescriber engagement and education (p. 13)
Reviewer 2	

It is well written, relevant and useful in improving current practice.	Thank you