Dear Reviewers,

Thank you very much for the time you have given up reviewing our paper, we are grateful for your comments and hope that we have been able to amend the text appropriately in response to the comments made. Any changes made are 'tracked' in the text and we have written comments in direct response to each of your comments below (in navy blue).

Yours sincerely,

Dr Melanie Nana

Reviewer: 1

Comments to the Author
generally well described - comments as noted

Would be helpful to understand more about the risk assessment as well as the patients

Is the risk assessment a binary decision? (Does benefit outweigh risk - y/n?) any differences in risk - high risk v not at risk v 'usual' risk

Thank you for your comments. To clarify, yes, the risk assessment is a binary decision, with patients being stratified into a benefit outweighing risk (Y/N) group as you describe. We have described the rationale behind this in the first paragraph of the 'problem' section. A three-tiered approach is used based on assessment of how mobile the patient will be in hospital, a review of patient-related risk factors and an assessment of their bleeding risk. I have clarified this in the third paragraph under the 'Problem' section.

for all the 39 patients in cycle #1 - was benefit thought to outweigh risk? (Denominator of dose adjustments = 39 suggesting that all pts were thought to require vte ppx - increasingly there are data suggesting that we may over prophylax hospitalized medical patients.)

Thank you for your comment- I hope this is now clarified by additional text added in paragraph 2 in the 'problem' section. We were assessing whether the patient had been risk assessed as opposed to prescribed VTE prophylaxis. Clinicians either write a prescription on the chart or sign to say that it is not required, and this constitutes as a proxy for the risk assessment.

How many pts on these gen med wards? 39 pts is what percentage of all pts? Generalizable?

There are 20 patients on each ward, so the 39 patients were across two medical wards. There are 10 general medical wards in our district general hospital and 10 surgical wards. We planned to do small 'tests of change', refining the intervention on two wards before trying it on a different set of two wards. In terms of general medical wards we concluded that this was generalisable in terms of improvement seen on both sets of wards. This is likely to be supported by the fact that these wards are made up of similar cohorts of patients and have similar staffing, for example, physicians, pharmacists, nursing staff so that the principle of the intervention could be replicated. We hope to expand the project into the surgical wards in future cycles- described in the penultimate paragraph of the lessons and limitations section.

Pts were pts admitted to a medical ward. Were the 39 patients at usual risk for VTE? High risk??
cancer? obesity? other?

We did not collect data on individual risk factors, rather whether a VTE risk assessment was carried out. The ward is a general medical setting with a range of patients with a variety of risk factors typical of those admitted into the medical intake in a district general hospital. I have clarified this in paragraph three of the 'measurement' section to make it clear.

For those of us not practicing in the UK please clarify in abstract - 25000 preventable deaths in UK (included in manuscript body)

Thank you for pointing this out- it has now been amended in the abstract.

Please describe what a drug chart is - is this similar to what we might call a medication administration record indicating dose of medication administered?

Thank you for pointing this out- I have added further clarification after the first mention of the 'drug chart' such that it now reads 'drug chart (medication prescription chart/medical administration record)'.

How is risk assessment documented in the medical record? (and abstracted) - is there specific language (benefit > risk) or is prescribing of prophylaxis a proxy for risk assessment? Was this part of the education (how to document)?

The prescription of prophylaxis is a proxy for risk assessment as such this was not included in the education- it could be a valuable point for future cycles, however. The clinician signs if a decision has been made not to prescribe prophylaxis demonstrating that an assessment has been made either way. I have made this clear in paragraph two of the 'problem' section

This is a nice, well written description of a multidisciplinary project. Is this generalizable? A significant investment (education etc) for a small number of patients.

To date we have demonstrated sustained improvement on two wards and similar levels of improvement on a further two wards demonstrating generalisability. We acknowledge that a significant investment was made by the team, however, this had the desired effect of improving compliance with VTE prophylaxis. Time taken to produce the sticker, teaching PowerPoint presentations, patient leaflets will not need to be repeated now that they have been developed.

In addition we have described some unexpected consequences of the work which also add value and justification to the work investment- these are described in the penultimate paragraph of the strategy section and include improved interdisciplinary morale and communication, training in QI methodology and feelings of empowerment to be able to improve the working environment.

While generally well written, there are some typos sprinkled throughout that should be corrected. (And a small note that data are plural)

Thank you this has now been addressed.

Reviewer: 2

Comments to the Author
Thank you for your hard work and making changes in response to my suggestions.

Thank you again for your helpful comments.