Author's response to reviews

Title: Patient-related information asymmetry disrupts pre-anaesthetic patient briefing: a prospective observational study

Authors:

Joerg Schnoor (joerg.schnoor@medizin.uni-leipzig.de)
Anja Kupfer (anja.kupfer@medizin.uni-leipzig.de)
Babette Jurack (babette.jurack@googlemail.com)
Ulrike Reuter (uli-reuter@gmx.de)
Herrmann Wrigge (herrmann.wrigge@medizin.uni-leipzig.de)
Steffen Friese (steffen.friese@medizin.uni-leipzig.de)
Volker Thieme (Volker.thieme@medizin.uni-leipzig.de)

Version: 2 Date: 24 June 2013

Author's response to reviews: see over
Revision

“Patient-related information asymmetry disrupts pre-anesthetic patient briefing: a prospective observational study”.

Dear Ladies and Gentlemen.

Many thanks for constructive proofing. We have considered all aspects and attached a revised version of the manuscript. The manuscript has been revised by a native speaker.

First of all we would like to suggest the new title

Asymmetry in patient-related information disrupts pre-anesthetic patient briefing: a prospective observational study

All further amendments relate to the following aspects:

A) Reviewer Hiroto Narimatsu

I. Page 7, second paragraph, (“typological error”):

“In 130 cases of disrupted patient briefings, the total time of disruptions totaled more than 8 hours while the average time delay was 2.5 minutes. When disrupted, each patient briefing …”

II: Page 9, second paragraph (“previous studies dealing with disruption by IT):

“The fragmented nature of delivering health care, the large volume of transactions, the need to integrate scientific evidence into practice, and a rising transfer of information make electronic information management systems more appropriate to address continuous quality improvements and patient safety initiatives [8,9]. Here, IT is at the crossroads of technology and patient safety. Anesthesia Information Management Systems (AIMS) show the potential to improve patient safety and quality in the perioperative setting. AIMS make legibility of documentation more feasible, which, in consequence, helps optimizing the exchange of complex health information [8]. In contrast, our data shows that using computer-based documentation and information systems was a significant nuisance. Overall, it is surprising that while financial investments to set up IT solutions had been justified by forecasted timesaving, nevertheless we found that about 1/5 of the time of disruption was caused by its use. Disruptions by IT have already been described. Criticism includes discomfort with rapid documentation and electronic data entry during short or emergency procedures and inconvenient placement of the system at the anesthesia workstation. A further barrier to adoption and implementation of IT seems to be the question about legal status with missing or outlier data [8,10]. In total, IT adoption will be decreased when interfaces between different software manufacturers or the lack of active physician involvement in planning, designing, and implementation of IT solutions still impede clinical practicability [8].”
B) Review Douglas Paull

I. Page 3, third paragraph (“safety issues of missing information”):

“Patients’ past medical history, medication, and physical examination merge into a preoperative image of the patient’s overall status, mandatory to choose the safest method of anesthesia. To meet this clinical standard, essential requirements for pre-anesthetic patient education include diverse information about patients’ past medical history, medication, examination findings, and the precise knowledge about planned surgical procedures.”

and Page 8, second paragraph

“While pre-anesthetic anticipation and planning are essential steps of risk management, missing test results and incomplete transfer of information can promote erroneous conclusions leading to poor decisions that ultimately jeopardize patient safety [5]. Also, life-threatening medication errors can be the result of missing or illegible documentation [6]. This is of rising concern since stakeholders in health care clearly emphasize particular interests in quality and safety of patient care. Conclusively, there still might be a contradiction between stated objectives and actual outcome that is simply caused by incomplete data collection. This might be due to cost-cutting measures through the change from cost allowance to a system of lump sum payment (DRG) associated with politically motivated staff shortages within the health care sector. As of now, this has induced notable reductions in average nursing minutes per day [7].”

II. Page 4, forth paragraph (“appendix protocol”):

For better understanding we included the data collection sheets as an appendix protocol at the end of the manuscript.

III. Page 8, second paragraph (“data not presented”): Unfortunately, data do not allow to a quantitative differentiation between each disruptive factors. Therefore, we could describe this aspect only in a descriptive manner.

“Rather than missing results of more technical investigations (echocardiography, chest X-ray, hematologic laboratory), we also found an imperfection of simpler physical examination results like blood pressure, body weight, and body seize (data not shown) that were usually provided by nurses.”

IV. Page 10, second paragraph (“benefits of the pre-anesthetic patient briefing”):

“Both the taking of patient’s past medical history and the physical examination are the basis of individual risk stratification of patients. Therefore, pre-anesthetic assessments promote patient safety. Our data demonstrate that consultants were less affected by information asymmetry then residents. In consequence, running an anesthetic pre-assessment clinic just by consultants might optimize patient contact time.”

V. Page 11, second paragraph (“how does the organization plan on dealing with these issues?”):

“Therefore, simple interdisciplinary arrangements to reduce asymmetries in information have been taken: first, prior to the patient’s presentation, simple test results (e.g. blood pressure, body weight and others) have to be documented by the caregivers. In addition, complete information regarding past medical history, medication, and the planned operational measures must be available. The data completeness has to be checked in the field of the anesthesia clinic right before consultation. Secondly, patients have to complete their questionnaire during their waiting period that has to be check by a nurse. These measures are mandatory prerequisites before patient consultation by the
anesthesiologist. It seems advisable to implement these simple measures accordingly, although patient status should allow exceptions. However, if exceptions reign supreme, this will be a none sustainable solution to the problem of asymmetry of information.”

VI. Page 8, first paragraph (“typological error”):

“After the change from cost allowance to a system of lump sum payment (DRG), politically motivated staff shortages within the care sector resulted in a reduction of the average nursing minutes per day [5].”

In addition, we included a few references:


We hope that the recent supplements will increase the value of our manuscript. Therefore, we would like to express our gratitude to the reviewers. We hope that this revision will find your acceptance.

Sincerely,
Joerg Schnoor