Pharmacy
STATEWIDE HOSPITAL PHARMACY

# The London Protocol: a multidisciplinary means to assess a clinical safety event

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## Background

Analysis of safety events is essential to determine systematic changes required to create a safer environment for patients. The London Protocol[1] is a recognised contemporary form of analysis that evaluates safety events via a small multidisciplinary team and is utilised for moderate to severe safety events reported in our organisation. This protocol has been adapted for practical use to ensure a **thoughtful, comprehensive** and **timely** analysis that extends beyond identification of individual fault. Analysis examines **all possible contributing factors**, as opposed a single root cause. Whilst less extensive than a full Root Cause Analysis (RCA), which is utilised for very severe events; the London Protocol provides a more efficient means of analysis, that can be completed in a reasonably short time-frame.

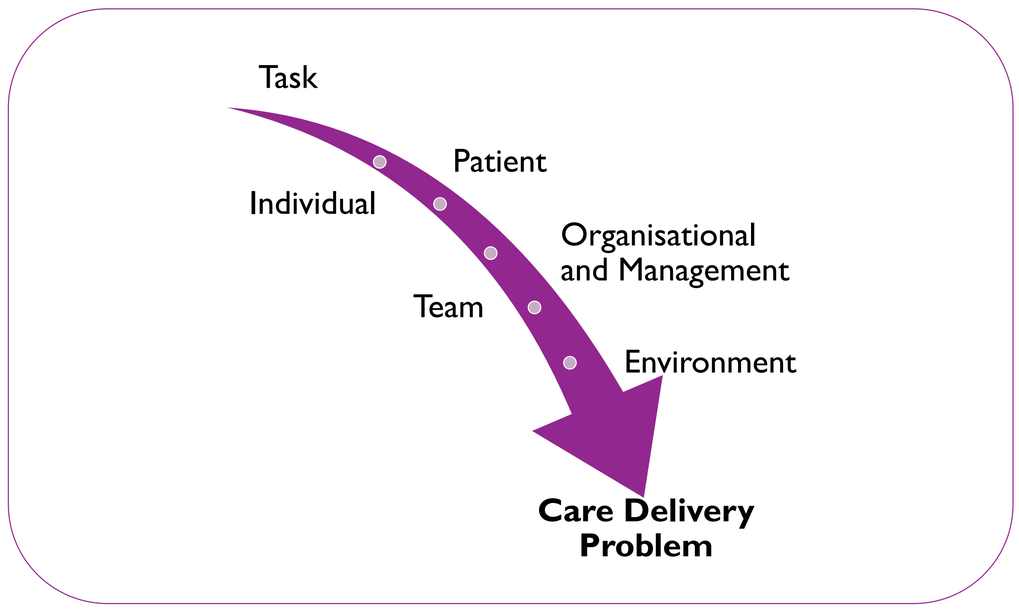


*Fig 1: Identification of contributory factors associated with a single care delivery problem[1]*

## Objective

The London Protocol was used to investigate the following reported clinical safety event: A patient admitted with an upper gastrointestinal bleed, venous thromboembolism (VTE) prophylaxis was considered but not charted throughout their stay. The patient deteriorated; investigations revealed massive bilateral pulmonary emboli, resulting in palliation and subsequent death of the patient.

## Action

- A London Protocol Panel was instigated including: a gastroenterologist, the Cardiology Ward Nurse Unit Manager, a Clinical Pharmacy Manager and a Safety and Quality nursing representative.
- The panel reviewed the incident report, and all relevant notes, charts and investigations. Interviews of staff involved in the patient's care were completed by panel members.
- The panel used London Protocol Framework to review the chronology of the event. A time-line of all factors leading up to the event was carefully reconstructed, whilst considering the information that was available to treating teams during the patient's stay.
- The panel members were able to comment on the appropriateness of decisions made at the time. This method of evaluation aims to avoid **hindsight** and **outcome bias** that may otherwise affect the quality of the investigation.

## London Protocol Process[2]

**Identification and decision to investigate**

**Select people for the investigation team**

**Organisation and data gathering**

**Determine the incident chronology**

**Identify and Care Delivery Problems (CDPs)**

**Identify the contributory factors and system failures**

**Make recommendations and developing an action plan**

## Evaluation

Through this framework, it was determined the patient was treated and managed appropriately, as per hospital protocols, given their co-morbidities and the information available to treating staff at the time. Potential contributing factors to the outcome included barriers around team-to-team communication, as well as barriers to timely investigations which may lead back to organisational/management and resourcing factors. A report detailing these systematic issues was then presented to the involved teams to allow for education, discussion and action. The London Protocol adheres to a strict timeline, with the entire process taking less than 70 days, meaning events are addressed relatively promptly.

## Discussion

Utilisation of the London Protocol allowed investigators to efficiently investigate this event. The panel could understand the context in which decisions were made, leading to a thorough and unbiased investigation of systems issues and human error, without assigning inappropriate blame on individuals. This incident can then be used to reflect on gaps or inadequacies in the health care system, allowing systematic issues to then be addressed, providing a safer environment for patients and staff.

## References:

1. *Taylor Adams A and Vincent C. Systems Analysis of Clinical Incidents: The London Protocol. Clinical Safety Research Unit, Imperial College London. London, 2004.*
2. *Oakley, A (2022) 'London Protocol Training.' [PowerPoint presentation] Quality and Patient Safety Service – South. Tasmanian Health Service- South. Accessed 23/08/2022*

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