**Implementation tool for**

 **the NCEPOD report**

**On The Right Course?**

Fishbone diagrams

Fishbone (or Ishikawa) diagrams are used to consider cause and effect. The starting point is a problem or incident and the diagram can help you to think about what contributed to it. All possible causes should be considered, not just the obvious or major ones.

We have provided some fishbone diagrams with issues that were identified during the study. Use any of these that are relevant to your organisation to start identifying possible causes. Major factors should go in the larger boxes at the end of the branches – more specific causes within those factors should go on the branches and you may even want to add contributing sub-branches. The diagrams we have provided are a starting point and should be adapted and expanded to fit your need. The final diagram is blank and can be copied or printed out blank for any additional issues you have identified.

This should be done as a multidisciplinary/team exercise to get different perspectives and as many potential causes as possible. Other quality improvement techniques, such as five whys and process mapping, could be used to help. We have included blank action plans for you to plan changes to practice and/or more quality improvement work.

Example:

Patient population

**Patients not concordant with medication**

Communication

Medication

Side-effects

Not sure when to take

Not felt to be working

Not sure how to take

Written information not always given

Unable to collect prescription

Not keen to have meds

For more information on quality improvement please see the following sources or contact your local Quality Improvement department:

Health Foundation: <https://www.health.org.uk/collection/improvement-projects-tools-and-resources>

King’s Fund: <https://www.kingsfund.org.uk/topics/quality-improvement>

NHS Improvement: <https://improvement.nhs.uk/resources/cause-and-effect-fishbone-diagram/>

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**New protocols of systemic anti-cancer therapy are not discussed at multidisciplinary team meetings before commencing treatment**

Suggested questions to ask:

Are new protocols being discussed at MDT meetings but not recorded?

If new protocols are not being discussed at MDT meetings, are they being discussed in other fora?

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| **Problem identified** | **Action required** | **By when?** | **Lead** |
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**Discussions with patients and/or parents about systemic anti-cancer therapy are not being documented**

Suggested questions to ask:

Are discussions taking place and not being documented?

Where discussions are taking place, do they include?:

* The intent of therapy (curative versus palliative)
* The chances of cure or the benefits of palliative therapy
* The risk of toxicity including that SACT can be life threatening
* Ceilings of treatment in patients with a poor prognosis

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**Assent for systemic anti-cancer treatment is not being sought from young people with capacity up to the age of 15 years**

Suggested questions to ask:

Are young people (up to 15 years) being involved in discussions and decision-making?

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**Consent is not being sought from patients aged 16 years or older**

Suggested questions to ask:

Are young people (up to 15 years) being involved in discussions and decision-making?

Who is giving consent on behalf of the young people?

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**Systemic anti-cancer therapy prescriptions are not checked and validated by a suitably trained doctor, nurse or pharmacist in SACT, other than the prescriber**

Suggested questions to ask:

Is this process covered in local policies/protocols?

Who is responsible for ensuring that this happens?

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**Patients in hospital are not receiving appropriate antibiotics within one hour of recognition of sepsis or suspected sepsis**

Suggested questions to ask:

Is this timeframe in local policy/protocol?

If yes, is clinical audit used to determine current practice and make improvements?

Who is responsible for ensuring that this happens?

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**Consultant review is not taking place within 14 hours of an acute admission**

Suggested questions to ask:

Is this timeframe in local policy/protocol?

If yes, is clinical audit used to determine current practice and make improvements?

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**Assessment of performance status of patients before administering systemic anti-cancer therapy is not routinely documented**

Suggested questions to ask:

Is performance status likely to be assessed but not documented?

Does local policy determine which performance assessment scales should be used?

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Suggested questions to ask:

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