**Implementation tool for**

**the NCEPOD report**

**Know the Score**

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/>

**Contents**

1. [Patient’s interim doses of anticoagulants are being delayed](#_Fishbone_diagram)
2. [PE severity assessment tools being used and documented](#_Fishbone_diagram_2)
3. [CTPA proformas reporting is inadequate](#_Fishbone_diagram_3)
4. [Low-risk patients are not being treated on the ambulatory care pathway](#_Fishbone_diagram_4)
5. [Patients are receiving patient information leaflets at discharge](#_Fishbone_diagram_5)
6. [Clinicians are not being alerted to CTPA/ V/Q or V/Q SPECT scan amendments to the report](#_Fishbone_diagram_6)
7. [Fishbone diagram - to be used for any locally identified issues](#_Fishbone_diagram_-)
8. [Fishbone diagram – to be used for any locally identified issues](#_Fishbone_diagram_–)

**Patient’s interim doses of anticoagulants are being delayed**

Suggested questions to ask:

Why are patients who are suspected of having acute pulmonary embolism not receiving interim doses of anticoagulant?

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**PE severity assessment tools being used and documented**

Suggested questions to ask:

Are PE severity assessment tools being used? Are the scores being documented in the notes?

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**CTPA proformas reporting is inadequate**

Suggested questions to ask:

Is there a standard format to the CTPA report? Is the presence or absence of right ventricular strain being recorded?

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**Low-risk patients are not being treated on the ambulatory care pathway**

Suggested questions to ask:

Is there a guideline in place for the treatment of PE patients via ambulatory care? Is the rationale for this choice documented in the case notes?

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**Patients are receiving patient information leaflets at discharge**

Suggested questions to ask:

Is a patient information leaflet for PE available? What information does this contain?

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**Clinicians are not being alerted to CTPA/ V/Q or V/Q SPECT scan amendments to the report**

Suggested questions to ask:

Is there a robust system in place to alert clinicians of changes to radiological reports?

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**<Insert issue>**

Suggested questions to ask:

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Suggested questions to ask:

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