**Implementation tool for**

**the NCEPOD report**

**Each and Every Need**

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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**Accurate diagnosis, distribution of motor impairment and tone variation not recorded**

Suggested questions to ask:

Is GMFCS level recorded? Where should it be recorded? Who should be recording this?

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**Weight and nutritional status not being assessed or recorded, and considered based on clinical needs**

Suggested questions to ask:

Is weighing equipment routinely available?

Is weight and nutritional status recorded at all health care encounters?

Are dieticians being included routinely as part of the care pathway?

Are nutritional assessments and status being recorded separately to the patient’s case note, such as dietician notes?

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**Patients not receiving routine oral health check-ups by lead clinician**

Suggested questions to ask:

Is oral/dental health recorded in clinical notes?

Is oral/dental health in the care pathway?

Are there clear referral pathways to dental care?

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**Patients’ preferred method of communication is not documented**

Suggested questions to ask:

Are patients being asked about their preferred method of communication?

Do staff feel confident to ask for this information?

Is there a space in the document to record this?

Are staff trained in making reasonable adjustments to support patients with complex communication needs?

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**Patients are not being involved in all communications and decision-making that includes them**

Suggested questions to ask:

Are patients and, where appropriate, carers being included in all correspondence about them?

Are consent procedures in line with the legal framework and good practice in this country?

Are patients being routinely asked for their preferences in regard to important decisions?

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**Medically frail patients do not have a working/ current Emergency Health Care Plan/ Emergency Care Summary**

Suggested questions to ask:

Where should this be recorded? Who should record it?

Does it contain details on who to contact and what to do in a range of scenarios

Are EHCPs reviewed/revalidated regularly?

Are DNACPR decisions recorded as part of EHCP routinely?

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**Appropriate pain scoring tools are not being used in the peri-operative/**

**peri-procedure period**

Suggested questions to ask:

Are staff aware of which tools to use, when and how?

Is pain scoring appropriate for patients with neurodisability included in protocols and pathways?

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**Lack of planning for transition from paediatric to adult services**

Suggested questions to ask:

Who should be responsible for initiating transition?

At what point should transition planning start?

Are primary care clinicians fully included in transition planning?

Are plans for transition fully integrated with other agencies (e.g. education, social care)?

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**Joint planning and preparation by surgical, anaesthetic and medical teams does not occur prior to admission for major surgery**

Suggested questions to ask:

Is there an anaesthetic pre-assessment clinic for patients with neurodisability?

Do joint meetings/discussions of team members occur routinely prior to admission of complex patients for surgery?

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**Patient with complex needs does not have a lead clinician**

Suggested questions to ask:

Who should lead care for children/young people with complex needs?

Why is a lead clinician not being allocated?

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**Hospital facilities are not fully accessible with appropriate equipment for patients with neurodisabling conditions**

Suggested questions to ask:

Who is responsible for ensuring that facilities are appropriately equipped?

What adjustments need to be made?

Is there feedback from patients and/or carers about problems accessing buildings or equipment in services?

Has an assessment of the facilities been carried out? (NCEPOD has provided a [facilities checklist](https://www.ncepod.org.uk/2018report1/downloads/Facilities_checklist.docx) to help with this.)

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Suggested questions to ask:

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