**Implementation tool for**

 **the NCEPOD report**

**Failure to Function**

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 needs. The final diagram is blank and can be copied or printed out 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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**Pre-alert system not used prior to arrival at hospital**

Suggested questions to ask:

Is there a pre-alert protocol locally? If yes, are all relevant staff aware of it?

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| **Problem identified** | **Action required** | **By when?** | **Lead** |
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**Natriuretic peptide measurement not carried out**

Suggested questions to ask:

Is there a difference between newly diagnosed patients and those already known to have heart failure?

Is natriuretic peptide measurement included in local protocols?

Do staff know when and why it should be carried out?

Why are staff not measuring natriuretic peptides?

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**Investigations and/or treatment not being carried out in the emergency department**

Suggested questions to ask:

Are there particular investigations or interventions that are not being carried out?

Are any particular patient groups missing out on investigations?

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**Patients not being measured by a heart failure specialist**

Suggested questions to ask:

Do all relevant services have access to a heart failure specialist? If so, do they know when and how to access them?

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**ECG is not being carried out**

Suggested questions to ask:

Do local policies and protocols include echocardiograms for all patients with suspected acute heart failure as early as possible after presentation to hospital, and within a maximum of 48 hours?

Are there specific groups of patients who are less likely to have an ECG?

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**Diuretic management was inadequate**

Suggested questions to ask:

Is diuretic management reassessed and adapted throughout treatment?

Is this included in care pathways?

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**Patients not being referred for, or discussed for, palliative care**

Suggested questions to ask:

Does the heart failure team include people with palliative care skills?

Do care pathways include when and how to involve palliative care?

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Suggested questions to ask:

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