**Implementation tool for**

**the NCEPOD report**

**Hard to Swallow?**

Fishbone diagrams

<https://www.ncepod.org.uk/2021dysphagia.html>

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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**The swallow status of patients with Parkinson’s disease is not routinely documented on referral to hospital**

Suggested questions to ask:

Was the patient’s swallowing status documented on referral?

Are problems with eating, drinking or swallowing medication being taken seriously by the healthcare team?

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**Patients with PD are not being screened for swallowing difficulties at admission**

Suggested questions to ask:

Did the patient have a history of aspiration pneumonia prior to admission?

Was an assessment of made of whether the patient had any symptoms of dysphagia on admission?

Was an assessment of the patient’s ability to swallow food, fluids and medication made at admission?

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**Patients with Parkinson’s disease with swallowing difficulties, are not being referred to Speech and Language Therapy (SLT)**

Suggested questions to ask:

Was a swallow screening undertaken? Was the patient referred to SLT as a result of the swallow screening?

When patients are referred to SLT, why is there a delay in referral?

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**The specialist Parkinson’s disease service is not being notified when a patient with PD is admitted**

Suggested questions to ask:

Was the patient under the care of a Parkinson’s disease service prior to admission?

Was the Parkinson’s disease service informed of the admission?

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**Parkinson’s disease patients with dysphagia are missing doses of medication.**

Suggested questions to ask:

Were any doses of medication missed if admitted via the emergency department?

Was it checked on admission that the patient had taken their last scheduled dose of medication for Parkinson’s disease?

Did the patient miss any doses of their medication during the admission? If so, why?

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**The nutritional status of patients admitted to hospital with Parkinson’s disease is not being screened.**

Suggested questions to ask:

Was a nutrition screen undertaken on admission?

Was the BAPEN Malnutrition Universal Screening Tool (MUST) score calculated?

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**Risk-feeding policy not being adhered to**

Suggested questions to ask:

Is there a risk-feeding policy at this hospital?

Why is the risk-feeding policy not being adhered to? Or was it adhered to?

Is mental capacity being assessed prior to the risk-feeding decision being made?

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**SLTs/ pharmacists/ dietitians/ nutrition teams are being omitted from the MDTs regarding patients with PD and swallowing difficulties**

Suggested questions to ask:

Should the patient have been discussed in an MDT meeting?

Was the patient discussed in an MDT meeting? Were SLT/Pharmacy/Dietetics/the Nutrition team involved in this meeting?

Was an appropriate MDT discussion undertaken during the admission?

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**Modified texture diets and fluids policy not being adhered to.**

Suggested questions to ask:

Is there a formal policy relating to the pathway for the provision of modified texture diet and fluids in place?

Was a modified texture diet advised? Was thickener was advised? Were catering/housekeeping and pharmacy notified?

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**On discharge, written information is not being provided on how to manage swallowing difficulties.**

Suggested questions to ask:

Were the effects of swallowing difficulties being communicated to the patient and/or carer relating to eating and drinking?

Were the effects of swallowing difficulties being communicated to the patient and/or carer regarding medicine administration?

Was there any communication with those caring for the patient in the community at discharge?

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Suggested questions to ask:

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