**Implementation tool for**

**the NCEPOD report**

**Making the Cut?**

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://www.england.nhs.uk/wp-content/uploads/2021/12/qsir-cause-and-effect-fishbone.pdf>

**Contents**

1. [Holistic care needs of patients not being met](#_Fishbone_diagram)
2. Patients with Crohn’s disease are not having their medication optimised
3. [IBD MDT meetings are not involving all relevant specialties](#_Fishbone_diagram_3)
4. [Patients are not being appropriately optimised prior to surgery](#_Fishbone_diagram_4)

1. [Abdominal surgery for Crohn’s disease is not being performed within 1 month of the decision to operate](#_Fishbone_diagram_5)
2. [Elective patients are presenting as emergency surgery admissions](#_Fishbone_diagram_6)
3. [Temporary stomas have not been closed after 12 months of insertion](#_Fishbone_diagram_7)

1. [The discharge of Crohn’s disease patients postoperatively is not being planned](#_Fishbone_diagram_8)
2. [Fishbone diagram 9 – to be used for any locally identified issues](#_Fishbone_diagram_9)
3. [Fishbone diagram 10 – to be used for any locally identified issues](#_Fishbone_diagram_10)

**1. Holistic care needs of patients not being met**

Suggested questions to ask:

Did the patient have access to psychological support? Did this patient have access to a dietitian?

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**2. Patients with Crohn’s disease are not having their medication optimised**

Suggested questions to ask:

Is a pre-operative medicines review taking place? Are there guidelines for the prescription of steroids for the treatment of Crohn’s disease patients? Does the guidance include consideration of bone and gastric protection when steroids are being prescribed to treat Crohn’s disease?

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**3. Insufficient MDT input for IBD patients**

Suggested questions to ask:

Is there a named coordinator of IBD MDT meetings? Is there a policy in place regarding MDT meetings? Does the policy include frequency of IBD MDT meetings and the relevant specialties to be involved?

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**4. Patients are not being appropriately optimised prior to surgery**

Suggested questions to ask:

Is smoking cessation being discussed with the patient ? Is NRT being offered? Are patient’s being offered nutrition and/ or dietetic advice?

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**5.Abdominal surgery for Crohn’s disease is not being performed within 1 month of the decision to operate**

Suggested questions to ask:

Is surgery for Crohn’s disease being correctly prioritised according to FSSA guidelines? Is there local guidance in place for theatre scheduling for Crohn’s disease patients?

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**6. Elective patients are presenting as emergency surgery admissions**

Suggested questions to ask:

Is surgery for Crohn’s disease being correctly prioritised? Are patients being reviewed whilst they are awaiting surgery? Do you have a plan for reviewing the care of patients awaiting surgery?

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**7. Temporary stomas have not been closed after 12 months of insertion**

Suggested questions to ask:

Is there a record of patients who have temporary stomas inserted? Is there a policy in place regarding the closure of temporary stomas? Was the stoma closed within 6 months?

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**8. The discharge of Crohn’s disease patients postoperatively is not being planned**

Suggested questions to ask:

Why are patients not being seen by gastroenterologists postoperatively and/ or prior to discharge? Why are patients not being seen by the IBD team postoperatively and/ or prior to discharge? How could handover from surgery to the medical teams be improved?

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Suggested questions to ask:

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Suggested questions to ask:

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