**Implementation tool for**

 **the NCEPOD report**

**Endometriosis: A Long and Painful Road**

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>

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7. [Fishbone diagram – to be used for any locally identified issues](#_Fishbone_diagram_7)

## **1. A patient with undiagnosed endometriosis, had to wait several months and repeated appointments in primary care, before waiting several months for an appointment with gynaecology, then wait another 6 months for a diagnostic laparoscopy**

Suggested questions to ask:

Are primary care clinicians, gynaecologists and gynaecology specialist nurses adequately trained in recognising signs and symptoms?

Is there a care pathway with target timeframes for referral for laparoscopy?

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**2. A patient who had been diagnosed with endometriosis 10 years previously, had undergone multiple laparoscopies, had a history of anxiety and depression had undergone deteriorating mental health, eventually presenting in A & E with an acute mental health crisis.**

Suggested questions to ask:

Was the patient asked about their mental health and the effect of endometriosis on their quality of life by the GP? The gynaecologist prior to surgery? Or at the follow-up appointment?

Was a standard Quality of Life questionnaire completed?

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**3. A young woman with known endometriosis was not prescribed hormone treatment as she was trying to conceive but had ineffective pain relief. There was no long-term care management plan**

Suggested questions to ask

Was the patient informed of all treatment options? Was a consultation/referral with the fertility service made? Were any referrals to the chronic pain service or alternative non-medical pain management e.g. physiotherapy.

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**4. A patient waited 5 years for a diagnosis and effective treatment of endometriosis**

Suggested questions to ask:

 Does the organisation have a documented pathway of care for patients with suspected endometriosis?

 Is the presence of this pathway communicated to all healthcare professionals involved in the care of this group of patients?

 Is there a multi-disciplinary team (that includes necessary AHPs) providing the endometriosis service?

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**5. A patient who had been diagnosed with endometriosis 8 months previously, was discharged with no follow-up appointment or medical management plan. They suffered a recurrence in symptoms but had to wait several months to be re-referred to gynaecology from their GP**

Suggested questions to ask:

On discharge from hospital, was the patient provided with follow up information? Were they provided with a scheduled follow-up appointment?

Was the patient provided with details of patient-initiated-follow-up? On discharge, were they provided with the details of direct access back into the secondary care pathway?

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**6.**

Suggested questions to ask:

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**7.**

Suggested questions to ask:

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