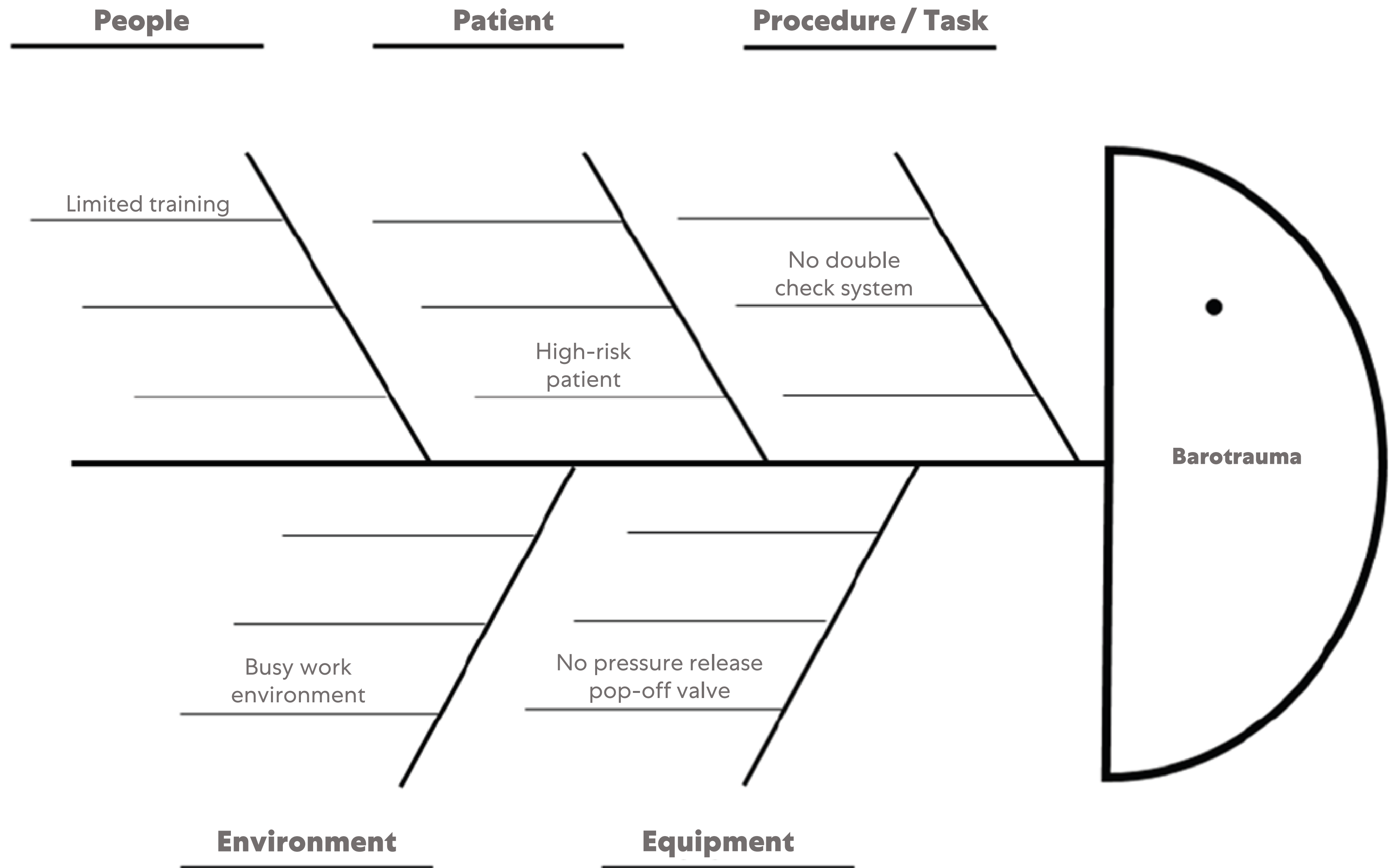
Fishbone

By: Kaoru Ishikawa

This is a visual model that can be used to look at possible factors that might have contributed to a patient safety event. The "error" is put in the head of the fish, and each spine represents an important possible contributing factor that could lead to that error. Key categories of possible contributing factors that are often part of a fishbone include Environment, People, Materials, Methods, and Equipment. There are often multiple contributing factors in a patient safety event.

Case Example:
A 6-year-old French bulldog experienced barotrauma while under anesthesia for dental procedure



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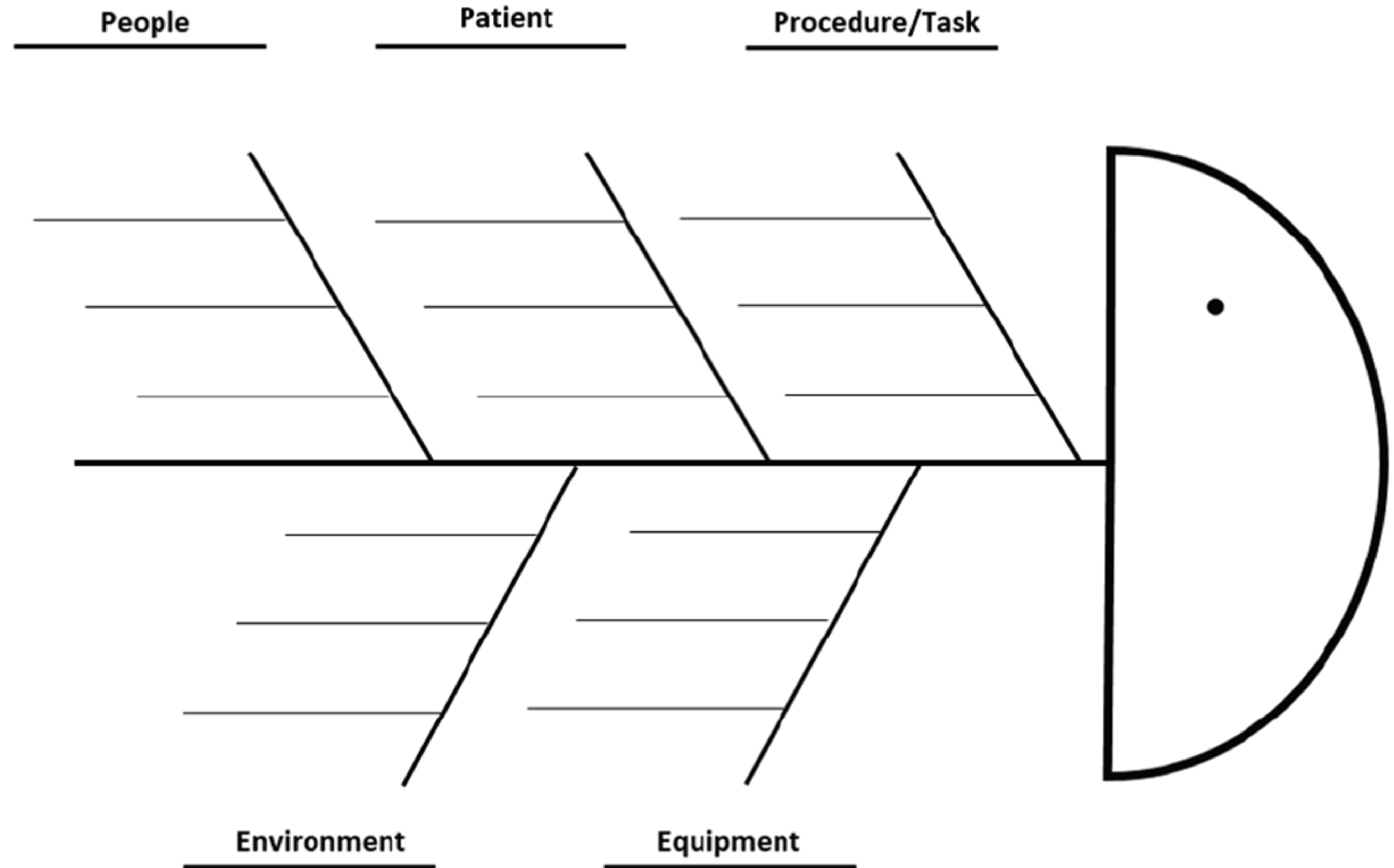
How can this be helpful?

In evaluating the event, use the model to see if any of the contributing factors (representing each spine of the fish) were involved in the incident. If an area is involved in a particular event (for example, a piece of equipment) discuss ways to improve / change this contributing factor, so it is no longer a factor in future events.



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