DRIVER DIAGRAM TO HELP IDENTIFY TACTICAL CHANGE IDEAS TO ENHANCE TRANSFUSION SAFETY

The Problem: Continuing trend in preventable transfusion errors reported to SHOT leading to patient harm including deaths. Common contributory factors identified include issues with staffing, training, safety culture and automation/IT.

A driver diagram is a simple, visual tool used to conceptualise issues and determine the system components which will then create a pathway to get to the goal. This tool helps support staff to systematically plan and structure improvement projects. Drivers are the factors/areas that you need to change to see improvement. Change ideas are the tactical changes to processes and things that staff could do differently which will impact on the drivers recognised. This is a dynamic document with some suggestions that teams can build on and amend to suit local needs.

Aims / Primary Outcome

Reduce errors and improve transfusion safety

1 Primary Driver

System components which will support achievement of the aim.

Improve staff wellbeing and enhance staff retention	Safe and clear communications within/between teams with effective workload management	Using IT and automation effectively to support and optimise processes	A just, learning culture with effective leadership to support safety and empower staff to report incorrect/unsafe practices

2 Secondary Driver

Elements of the associated primary driver. They can be used to create projects or change packages that will affect the primary driver.

Improve staff wellbeing and enhance staff retention	Safe and clear communications within/between teams with effective workload management	Using IT and automation effectively to support and optimise processes	A just, learning culture with effective leadership to support safety and empower staff to report incorrect/unsafe practices
• Workforce capacity and capability with a system for learning • Psychological safety and staff wellbeing • Inclusion and involvement • Structures and processes that enable safe, person-centered care	• Rationalise workload for staff • Staff skills: appropriate language, format and content • Practice using standardised tools for communication • Management of communication in different situations	• Relevant and appropriate IT at all stages of transfusion practice (clinical and laboratory) • Interoperability, interfacing and integration • Transfusion IT expertise • Sharing and learning between organisations	• Learning from excellence and everyday events • Systems thinking in process design and incident investigations • Listening and supportive leadership • Effective risk assessments • Sharing and learning from incidents and near misses • Application of human factors and ergonomics principles in designing systems and when investigating incidents

Tactical Change Ideas

Change ideas that will impact on the primary driver.

Improve staff wellbeing and enhance staff retention	Safe and clear communications within/between teams with effective workload management	Using IT and automation effectively to support and optimise processes	A just, learning culture with effective leadership to support safety and empower staff to report incorrect/unsafe practices
• Formal, agreed and monitored capacity plan • Work smarter concepts such as reducing duplication of tasks • Staff suggestions for improvement • Strategies to ensure staff wellbeing and mental health are considered • Strategies to improve team bonding (e.g., Team lunch on Fridays or Tuesday's team walk; 'fuddles' – a huddle combined with food) • Wellbeing check ins • Feedback and listening sessions • Regular staff surveys and informal, safe, drop-in sessions to identify areas of concern	• Communication skills training for staff and simulation-based multidisciplinary learning • Formal, structured and documented handovers • Review workload patterns • Team rotation to ensure competency compliance and expertise • Standard responses tools for common queries to laboratory to ensure consistent responses	• Business case for improved, validated and properly implemented IT solutions • IT training for laboratory staff • Support from IT departments • Funding and resources for upgrades and replacement systems • Review of IT requirements • Collect information from incidents and near misses for future IT upgrades • Involving IT in transfusion team meetings/hospital transfusion committee/debriefs where things have gone wrong, and IT has compounded errors • Informing IT of any planned changes/upgrades/new equipment before they occur • Good communication links and mutual understanding between IT and transfusion teams to ensure that staff are informed of any changes/upgrades so that revalidation required can be completed	• Training for all staff in just culture; human factors and ergonomics principles • Just culture/human factors embedded in incident investigation • Incident investigation and risk assessment training for leaders • Debriefs following incidents and excellent events • Empowerment of staff to lead change • Intentional inclusivity and cultural humility • Leading by example • Visual aids e.g., posters reinforcing who to speak out safely to, and how • Incorporate a 'safe space' system – this may be a post box/suggestion box where concerns can be raised and brought to staff meeting. Staff must feel there is an open and honest environment

Measures

Aim Measures:

- Reduction in incidents resulting in patient harm reported to SHOT
- Improved trends as evidenced by SHOT reports and surveys
- Increase in the number of ACE reports to SHOT

USEFUL RESOURCES

https://www.ihi.org/resources/Pages/Tools/Driver-Diagram.aspx
https://www.england.nhs.uk/wp-content/uploads/2022/01/qsir-driver-diagrams.pdf
https://learn.nes.nhs.scot/2278/quality-improvement-zone/qi-tools/driver-diagram

SHOT
Serious Hazards of Transfusion

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