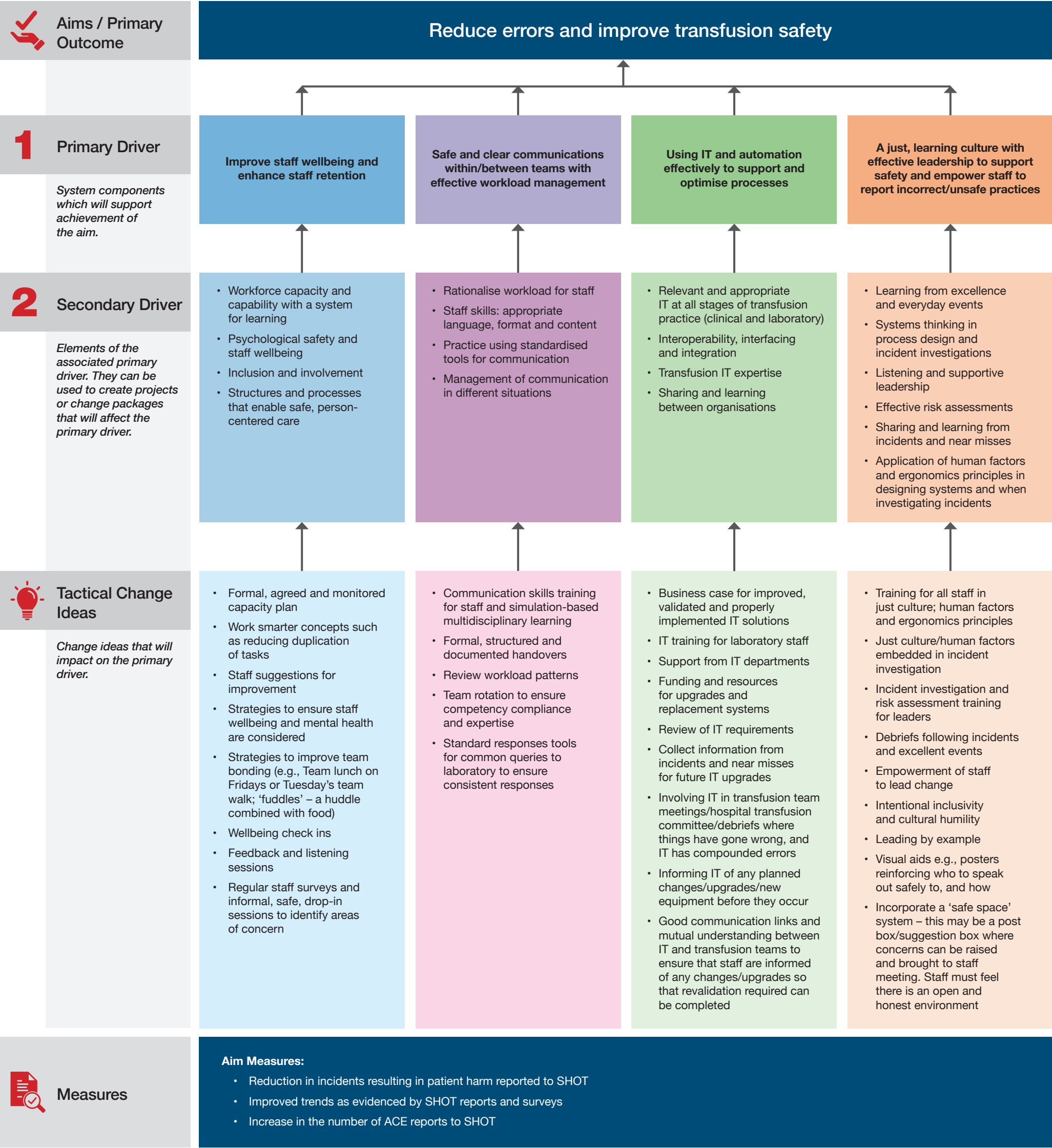


DRIVER DIAGRAM TO HELP IDENTIFY TACTICAL CHANGE IDEAS TO ENHANCE TRANSFUSION SAFETY

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.



USEFUL RESOURCES  
<https://www.ihl.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>

