Photo identification interim evaluation report

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1 Introduction

1.1 This report is part of a joint blood safety project (Right patient, right blood) between the National Patient Safety Agency (NPSA), the Chief Medical Officer's National Blood Transfusion Committee (NBTC) and Serious Hazards of Transfusion (SHOT).

1.2 During a blood safety workshop held in December 2004, the NPSA announced a target of reducing the number of ABO incompatible transfusion incidents by 50 per cent over three to five years, as measured by the SHOT database.

1.3 During the course of this workshop, photo identification (ID) was selected as one of four initiatives for further development and testing.

1.4 National Comparative Audit of Blood Transfusion re-audit of bedside transfusion practice established that patients receiving blood as an outpatient or day case do not always wear wristbands.\(^1\) Photo ID cards offer the potential for a sustainable means of identifying patients. They may be used as an alternative to wristbands for patients who are transfusion-dependent and receiving regular blood transfusions as outpatient or day cases.

1.5 The North Middlesex Hospital is currently issuing photo ID cards to transfusion-dependent patients. The NPSA has reviewed their system and developed it for national use.

1.6 In order to assess the effectiveness of the photo ID scheme, and the materials produced by the NPSA to support implementing such a scheme, the following evaluation methods were used:

- risk assessment;
- pilot of the scheme at five sites over three months;
- interim surveys with those involved in the pilot;
- user group meeting;
- patient workshop.

1.7 This report summarises the interim results of this evaluation and in particular:

- the scheme’s impact;
- feedback received from patients and healthcare staff;
- the effectiveness of the NPSA’s supporting materials;
- the lessons learnt.

2 Steering group

2.1 A steering group was established in May 2005 to consider the concept of photo ID, to risk-assess the process and determine whether the photo ID scheme could offer a workable national solution given necessary guidance and support from the NPSA.

2.2 Specific objectives were defined as:

- to review the photo ID scheme developed at North Middlesex Hospital, and develop further as appropriate, taking into account the experience of other hospitals that use photos as a means of checking patient identity;
- make an informed recommendation to the NHS on the benefits and risks of introducing photo ID for transfusion-dependent patients, including, if appropriate, a national standard for use;
- make recommendations on the transferability of photo ID cards to other patient groups.

2.3 A generic photo ID process was defined, building on the work of North Middlesex Hospital. A guidance document for setting up a photo ID scheme and summary of the risk assessment were produced (see appendix three). In order to aid patient understanding of the process it was agreed that a patient leaflet should be produced to explain clearly what the process involved and what patients would be expected to do.

2.4 Appropriate hospitals that could pilot the photo ID scheme were identified. The criteria for including pilot sites and how the pilot would be conducted were discussed and agreed. The pilot’s objectives were also set.

3 Patient workshop

3.1 In November 2005, a patient workshop was held to capture the views of patients who have received blood transfusions and their carers. The focus of the workshop was to draw on the participants’ experience of having their identity checked when receiving blood transfusions. Sixteen people took part in the workshop. Of these, 14 were people with sickle cell anaemia (or parents of children with the disease), one person had leukaemia and one represented a patient with leukaemia. All participants had been recruited via relevant organisations: Sickle Watch, Merton Sickle Cell and Thalassaemia Group, Waltham Forest Sickle Cell Action and Support Group, Makanga Koy Anane Bertrand and Leukaemia Care. In addition, there was an observer from the National Blood Service, and a consultant haematologist who chaired the steering group.

3.2 The photo ID scheme was explained to the participants and their initial views were recorded.

3.3 Participants generally welcomed the idea. It was seen to provide all the information that hospital staff required at a single point, and it was thought that checking identity could become very straightforward with a photo ID card.
3.4 Some participants thought it would save time as it stopped staff asking questions repeatedly.

3.5 Few participants had reservations about having their photo on a card. This was felt to be no different to a passport or driving licence photo. Several suggested that a photo should also be on patients’ notes.

3.6 Some people were reluctant to have their photo taken. However, this was on the grounds that they were not photogenic or a person’s appearance might change due to, for example, having chemotherapy and losing their hair. Some participants welcomed the suggestion that the photo could be changed if people felt they had physically changed.

3.7 Participants thought they were less likely to lose a card than a wristband, at least whilst in hospital, as the latter had a tendency to slip off the wrist or be removed by nurses when undertaking some procedures.

3.8 The comments were fed back to the steering group and were reflected in the photo ID guidance document that has been produced.

4 Photo identification pilot

4.1 For the pilot study, the trust was required to provide transfusion-dependent patients with photo ID cards, which contained all the details that would normally be on a wristband. The patients were then asked to bring this card with them each time they have a blood transfusion, thus replacing the requirement for a wristband. Patients had to consent to being part of the pilot and to sign a central register to confirm that the photo taken of them was a true likeness. The photos were then deleted permanently from the photographic equipment.

4.2 Trusts were also required to complete audit forms and questionnaires for the duration of the pilot. These would assess the effectiveness of photo ID cards as an alternative method for checking patients’ identities.

5 Rationale for the pilot

5.1 The rationale for the pilot was to conduct a structured assessment of the impact of the photo ID scheme. The pilot was designed to measure the photo ID card’s effectiveness as a method for checking identity, and how reliable it was when used by patients.

5.2 The pilot was designed to look at:

- staff perception and co-operation with the identity checking process;
- patient perception and co-operation with the identity checking process and effect on their sense of empowerment;
- compliance against ID checking process;
- practicality of the cards in terms of their reliability and durability;
- the usefulness of:
  - photo ID guidance;
  - photo ID patient leaflet;
  - IT specification example.
6 Method of pilot

6.1 In order to maximise the learning from the pilot, trusts were identified as eligible to participate if they transfused a minimum of 10 transfusion-dependent patients every two weeks.

6.2 Transfusion-dependent patients were offered a photo ID card if:

- they had regular blood transfusions (at least once every three months);
- they, or their parent or carer, agreed to a photo ID being issued;
- they understood how the photo ID was to be used.

6.3 Patients issued with a photo ID card were reviewed at appropriate intervals and the card withdrawn if they no longer met the inclusion criteria. Any transfusions required after this would be given in accordance with standard trust policy on blood sampling and administration.

7 Design of pilot

7.1 NPSA representatives visited the sites involved in the pilot and provided supporting information.

7.2 The pilot sites were issued with:

- leaflets;
- guidance packs;
- an example of an IT specification for photo ID equipment.

7.3 Trusts were also issued with a letter outlining the aims and requirements of the project (see appendix one).

7.4 The key actions required by trusts involved in the pilot included:

- completion of an audit (extracted from the National Comparative Blood Transfusion (NCBT) Audit) of wristband compliance, before and after the introduction of photo ID cards;
- procurement and implementation of photo ID equipment;
- completion of a before and after audit of staff perception of the process;
- completion of an audit of patient attendance and use of the photo ID card to examine the reliability and durability of the system.

7.5 The pilot ran for three months, to allow for sufficient time to collate information relating to patient re-visits.

7.6 A pre-requisite of the pilot was that trusts would have photo ID equipment available.

7.7 Questionnaires were produced for trusts to fill out (see appendix five). This maximised the learning from the pilots.
8 Audit

8.1 An audit, extracted from the NCBT audit was undertaken on 20 cases. Sites completed the audit before starting the pilot and repeated them at the end of three months. The aim of the audit was to determine whether compliance with checking patients' identities changed in any way.

8.2 Pre-pilot and post-pilot perception questionnaires were given to approximately 10 staff who were directly involved in the pilot. The pre-pilot and post-pilot questionnaires were issued to the same staff. The aim was to identify changes in perception.

8.3 A patient enrolment form was completed by the consultant or person undertaking the assessment for every transfusion-dependent patient. One enrolment form per person was completed. The aim of the form was to establish the number of patients eligible for the project and how many agreed to participate. It also captured any reasons why patients did not enrol. It could also be used as a checklist for the process of enrolling patients and the information required.

8.4 An event analysis form was completed by all patients that enrolled on the pilot each time they visited the hospital. This allowed patient visits and the number of times the photo ID card was remembered to be tracked. It also established whether or not the photo ID card needed to be replaced. These forms are all available in the photo ID guide.

8.5 Each pilot site was provided with a site code to ensure anonymity when forms were returned. A member of staff not involved in issuing the site codes entered the forms onto the computer. Patient details were not included on the forms which were returned to the NPSA. The central register held by each pilot site included a column for issuing a unique NPSA number to each patient taking part in the pilot.

8.6 The questionnaires were collated throughout the three-month period and entered on to a database. Comment boxes were assessed and a summary of comments will be included in the final evaluation report.

8.7 Project leads, or those closely involved with the administration of the project, were asked during a telephone survey to provide their views on the project using the staff perception questionnaires as a basis (see appendix five). Only qualitative observations will be expressed based on these responses.
9 Early learning from pilot sites

9.1 Interim feedback from the pilot sites has identified valuable insights and lessons for future work. The feedback is summarised in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Feedback</th>
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</table>
| Set up of photo ID scheme                    | Problems were encountered with the IT equipment and the support required for setting up the photo ID scheme. When introducing the scheme, consideration needs to be given to:  
  - the need for IT support;  
  - the need for the equipment to be self-contained.  
  The use of a portable laptop with the photo ID software installed would be beneficial as it could be easily transported between different sites and could be taken to the patient rather than establishing a standalone photo ID processing area. This would also mean that the equipment could be locked away when not in use. |
| Photo ID card                                | Each pilot site adopted different forms of cards. At one site, patients were issued with a plastic card which they could put in their wallet as they would a credit card, potentially reducing the likelihood of them forgetting to bring their cards with them. Patients were offered a holder (a necklace or clip) so that they could display their card whilst in hospital. They then returned the holder when they left. There is a danger that unless issued with a badge holder, patients will not be asked to show their card. |
| Patient leaflet                              | The patient leaflet was found to be simple and easy to understand. It was suggested that it should also be made available in large print. Two pilot sites noted that, while patients considered the leaflet useful, they did not refer to it and some were dismissive of it. Patients preferred to listen to an explanation of the scheme from a haematology nurse. |
| Guidance document                            | The guidance document was found to be useful and easy to follow, but was seen as largely for use by those leading the project and setting up the scheme. The document in its entirety was not considered applicable to all staff and only relevant extracts were photocopied and issued to the wider number of staff involved with the day-to-day administration of the photo ID scheme. |
| Patient empowerment                          | All pilot sites agreed that the photo ID scheme had a significant impact on patient empowerment. Patients reacted extremely positively towards it and preferred the photo ID card to the wristband, which many reported not liking. The photo ID cards made patients feel more involved in their own care and able to drive the process of checking. They also liked the fact that it was an easy method for showing their details and allowed for quick checking procedures. |
| Reducing misidentification incidents and improving compliance with identity checking | The pilot sites felt the scheme would help reduce the number of misidentification incidents because patients were involved in driving the checking process. However, it was felt that the photo ID process would not improve staff compliance with identity checks because those members of staff inclined not to check patients’ identities would not change their practice because of a different method of checking. The issue of chronic patients being familiar to
staff, and therefore not being checked, would still be an issue.

| Time | Patients and reception staff reported that photo ID cards sped up the booking-in process as patients can easily show their cards at reception. |

10 Timescale for completion of project

10.1 All five trusts have commenced with the pilot work and, whilst they are at different stages, it is anticipated that they will all have completed it by mid-October 2006. Information will be gathered from the pilot sites up to this date, and entered on to the project database for further analysis. The completed evaluation report will be finalised by mid-November 2006.

10.2 A further workshop is planned to look at the potential for using photo ID in other clinical areas, depending on the outcome of the full evaluation.

11 Further information

11.1 If organisations are considering implementing the photo ID scheme, it is suggested that they contact the pilot sites below for further information:

Karen Madgwick  
Transfusion Practitioner  
North Middlesex  
University Hospital NHS Trust  
Edmonton  
London, N18 1QX  
Telephone: 020 8887 2773

Karen Shreeve  
Transfusion Practitioner  
Morriston Hospital  
Swansea NHS Trust  
Heol Maes Eglwys  
Morriston  
Swansea  
SA6 6NL  
Telephone: 01792 704005
12 Acknowledgements

Many thanks to the hard work and co-operation of all our pilot sites:

Barts & The Royal London Hospitals
Whitechapel
London
E1 1BB

Swansea NHS Trust
Singleton Hospital
Sketty Lane
Swansea
SA2 8QA

Freeman Hospital
High Heaton
Newcastle Upon Tyne
NE7 7DN

North Middlesex
University Hospital NHS Trust
Edmonton
London
N18 1QX

Dudley Group of Hospitals
Russells Hall Hospital
Dudley
West Midlands
DY1 2HQ
Appendix 1 – Letter to chief executives

National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD
Tel: 020 7927 9500

Dear XXXX

You may be aware that the NPSA is currently leading on a joint project being undertaken in conjunction with SHOT and the NBTC to reduce the incidence of ABO incompatible transfusions due to failure of bedside checks. One initiative in this project is to further develop and test a scheme recently introduced at the North Middlesex Hospital, where photo identification (ID) is now used for transfusion dependent patients.

Under this scheme, patients are provided with a photo ID card which contains all the details that would normally be on a wristband. They are then asked to bring this card with them each time they have a blood transfusion. This replaces the requirement for a wristband to be produced each time they go to hospital.

We are now going to test, in a small number of hospitals, the procedure that we have developed for the use of photo ID cards. To maximise our learning from this, we are identifying hospitals that transfuse a minimum of 10 transfusion dependent patients every two weeks.

I am writing to ask if you would be willing for your hospital to be involved in this pilot stage of the project. It is anticipated that it would run for approximately three months from the beginning of December 2005.

Involvement in this pilot would include:

- assessing transfusion dependent patients when they are seen in the clinic as to whether it is appropriate for them to use a photo ID card;
- gaining consent from the patient to use photo ID;
- producing photo ID cards for these patients in a timely manner;
- using a patient information leaflet to inform patients how their photo ID card is used;
- auditing wristband compliance for this group of patients before and after the introduction of photo ID – this would require two days of an auditor’s time.

For this system to be successful, it will be necessary to have easy access to electronic photo ID equipment in the outpatient department so that the photo can be taken once the patient has given their consent.

If you agree to become a pilot site, the NPSA will provide funds (maximum of £2,000) to purchase electronic photo ID equipment and the services of an auditor for two days. Further information on the type of equipment required will be provided.

If you are willing to be involved in this pilot, or would like to discuss potential involvement, contact Julie Rix, Patient Safety Manager, NPSA on 029 20226672 or email: julie.rix@npsa.nhs.uk
If you would like to be involved, I would appreciate it if you could contact us by 8 December 2005.

Yours sincerely,

Professor Sir John Lilleyman
Medical Director
National Patient Safety Agency
Appendix 2 – Specification for electronic ID card scheme

A typical piece of equipment would include an electronic card system with easy-to-use and set up software (Windows 2000 and XP compatible). The software would include:

- user-defined database and data entry screen;
- integrated card designer with badge preview;
- full database search facility.

It also comes with a colour card printer (that takes CR80 cards) that features:

- easy-to-use batch printing;
- digital camera or USB web cam;
- ink ribbon for 100 cards (it is possible to pre-print the back of the card);
- 100 clear landscape badge holders;
- 100 black lanyards with safety breakaway.
Appendix 3 – Photo ID risk assessment summary

- A principle risk, which was identified at several points in the process, is that the photo on the ID card may actually lead to a reduction in the safety of the identity checking process. There could be an over-reliance on the photo that may give the person checking patients’ identities a false sense of security. One of the ways this risk could be reduced is to ensure that the photo itself is not used when checking the patient’s identity against the blood product. The photo serves no purpose at this stage. If the photograph was on the opposite side of the card to the identity data, this may prevent its use at this stage.

- The need for patient involvement and understanding of the photo ID process is a recurring control needed throughout the process. It is therefore crucial that the photo ID should in no way remove the need for verification of identity with the patients themselves at any stage before transfusion.

- Data protection issues are reduced by not retaining the photo. There are no real benefits from retaining the photo.

- If at any stage a patient’s identity cannot be verified, the process should be stopped and there should be a transfer to the default method of using a wristband for identification. A poor quality photo, but correct and verifiable data, should not necessitate default to a wristband, but should require the renewal of the photo after the current treatment, but before the next.

- Overall, despite the difficulty in trying to accurately score the risks identified in the photo ID process, no risk scores are greater than ‘low’.
## Appendix 4 – Risk assessment

Risk ranking key: C – consequence; L – likelihood; R – risk

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<thead>
<tr>
<th>Stage in process</th>
<th>No.</th>
<th>What could go wrong?</th>
<th>Causes</th>
<th>Consequences</th>
<th>Controls</th>
<th>Risk ranking</th>
<th>Solutions, ideas, recommendations</th>
<th>Actions for group</th>
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<tbody>
<tr>
<td>Patient assessed as suitable for photo ID</td>
<td>1</td>
<td>Inappropriate patient identified</td>
<td>Assessing person not appropriately trained</td>
<td>Wasted resources</td>
<td>Adequate training</td>
<td>1 2 2</td>
<td>Clear criteria for inclusion</td>
<td>Produce patient information leaflet</td>
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<td>Patient complaint</td>
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<td>Patient information and involvement</td>
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<td>2</td>
<td>Patient not assessed and not included when should be</td>
<td>Assessing person not appropriately trained</td>
<td>Wasted resources</td>
<td>Adequate training</td>
<td>1 2 2</td>
<td>Clear criteria for inclusion</td>
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<td>Patient information and involvement</td>
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<td>3</td>
<td>Patients not included – feels system is inequitable</td>
<td>Lack of patient information and understanding</td>
<td>Patient complaint</td>
<td>Patient information and involvement</td>
<td>1 1 1</td>
<td>Develop patient information on the use of photo ID for determining identification</td>
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<td>4</td>
<td>Criteria not set or incorrectly set for inclusion</td>
<td>Lack of training and understanding by staff</td>
<td>Inappropriate patients included</td>
<td>Adequate training for staff</td>
<td>2 1 2</td>
<td>Develop model guidance on inclusion criteria for trusts to adapt</td>
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<td>Information given and patient gives consent for photo</td>
<td>5</td>
<td>Patient does not give consent for photo</td>
<td>Lack of patient information and understanding</td>
<td>Not included in photo ID process</td>
<td>Revert to default position</td>
<td>1 1 1</td>
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<td>Patient adverse to being photographed or fearful of purpose</td>
<td>Patient complaint</td>
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<td>Ensure adequate patient understanding and involvement</td>
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<td>6</td>
<td>Consent not informed</td>
<td>Lack of information given or lack of understanding by patient regarding use of photo</td>
<td>Possible litigation</td>
<td>Adequate education and training</td>
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<td>Patient information and involvement</td>
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<tr>
<td>Photo ID card produced and given to patient</td>
<td>7</td>
<td>Poor quality likeness of patient</td>
<td>Poor quality equipment</td>
<td>Not suitable for purpose of correctly identifying patient</td>
<td>Equipment is of suitable standard</td>
<td>1 1 1</td>
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<td></td>
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<td>Staff not trained in use of equipment</td>
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<td>Adequate training in use of photographic equipment</td>
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<td>Patient unwell on day of photography</td>
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<td>Use existing photographic services</td>
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<table>
<thead>
<tr>
<th>Solutions, ideas, recommendations</th>
<th>Actions for group</th>
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<tbody>
<tr>
<td>Develop patient information on use of photo ID – user-friendly format</td>
<td>Produce patient information leaflet</td>
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<td>Raise patient awareness of safety issues through their involvement</td>
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<td>Clarity on consent process including clear reasons for using photo ID and that photographic image will be destroyed and not kept</td>
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<td>Provide guidance on equipment</td>
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<td>Repeat photo until good likeness achieved</td>
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<td>Produce guidance information on how to manufacture the photo ID card</td>
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<tr>
<td>Stage in process</td>
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</tbody>
</table>
|                  | 8   | Incorrect info on photo ID card | Staff did not check ID details against documentation and with patient prior to producing the card  
ID details checked but transcribing error during manufacturing of card  
Variation in demographic details provided by patient and with hospital documentation | Wasted resources as card will need to be reproduced | Ensure written ID details are correct at time of production | 1 1 1 | Provide guidance for the production of all photo ID cards recommending checks of PAS data, laboratory data and hospital notes |
<table>
<thead>
<tr>
<th>Stage in process</th>
<th>No.</th>
<th>What could go wrong?</th>
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<th>Controls</th>
<th>Risk ranking</th>
<th>Solutions, ideas, recommendations</th>
<th>Actions for group</th>
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</table>
|                  | 9   | Patient unable to read or verify data on card due to insufficient understanding | Patient inappropriately assessed as suitable for photo ID | None if others can verify details and confirm patient ID | Adequate training of staff | 1 1 | 1 | Clear criteria for inclusion
|                  |     |                      |        | Potentially wasted resources if patient doesn't understand the need to wear photo ID or bring to appointments | Clear inclusion criteria | | | Training of assessorors |
|                  | 10  | Patient given wrong card | Photo ID card not checked with patient when handed over | Delay in transfusion process | Adequate training of staff in determining patient ID | 2 1 | 2 | Register of photo cards produced
<p>|                  |     |                      |        | Wasted resources as other methods for confirming ID needed | | | | Patients sign on receipt of checked ID card |
|                  | 11  | Patient has multiple unique identifiers | Criteria not followed for confirming patient ID details | Delay in transfusion process if unique identifiers don't match transfusion documentation and products | Agree which unique identifier is used on photo ID card | 2 1 | 2 | Refer to blood transfusion department for unique identifier number |</p>
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<tr>
<td><strong>Register of patients using photo ID</strong></td>
<td>12</td>
<td>Failure to register photo taken</td>
<td>No register system kept in department of which patients use photo ID and which don’t</td>
<td>Wasted resources if an ID bracelet is written out for a patient who uses photo ID instead</td>
<td>Register of all photo ID patients kept in department including date of photo and staff member taking photo</td>
<td>1 1 1</td>
<td>Register of photo cards produced Patients sign on receipt of checked ID card</td>
<td>Incorporate in guidance information for photo ID card production</td>
</tr>
<tr>
<td><strong>Photo ID used when sample taken for cross match</strong></td>
<td>13</td>
<td>Wrong details recorded with sample</td>
<td>No adequate checking process when taking blood samples</td>
<td>Delay and inconvenience to patient – second sample taken</td>
<td>ID data checked prior to blood being taken and again once recorded</td>
<td>3 1 3</td>
<td>National/trust policy on sample taking</td>
<td>Produce guidance information for staff on how to use photo ID when checking a patient’s ID prior to sample taking and blood administration</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Photo ID lost</td>
<td>Not looked after by patient Stolen</td>
<td>Delay in confirming patient ID</td>
<td>Default to other system</td>
<td>1 2 2</td>
<td>Default to other system</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>Photo not a good likeness</td>
<td>Patient’s appearance now different from when photo taken Quality of photo/condition of card makes likeness difficult to establish</td>
<td>Delay in confirming patient ID, though minimal if written details are correct</td>
<td>Use written ID details to confirm ID Default to verbal checks</td>
<td>1 1 1</td>
<td>Ensure photo ID cards are checked at every visit for continued likeness to patient Use renewal dates where necessary</td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Stage in process</th>
<th>No.</th>
<th>What could go wrong?</th>
<th>Causes</th>
<th>Consequences</th>
<th>Controls</th>
<th>Risk ranking</th>
<th>Solutions, ideas, recommendations</th>
<th>Actions for group</th>
</tr>
</thead>
</table>
|                  | 16  | Patient has someone else’s ID | Given the wrong card when produced  
Swapped card with fellow patient | Delay  
Potentially wrong sample cross match with wrong details | Process stopped  
Remove card if details incorrect and destroy and renew  
Revert to written documentation and check against request form | 2 1 2 | National trust policy on sample taking and checking patient ID data |                  |
|                  | 17  | Conflict between photo ID and request form | Patient circumstances have changed e.g. marriage, house move | Potential delay of the process | Stop process and check against other documentation and with patient  
New request form required | 2 1 2 | National trust policy on sample taking and checking patient ID data |                  |
|                  | 18  | Change in phlebotomy system leads to complications | Any change to a familiar system has the potential to cause error | Possibility of incorrect sample and misidentification | Thorough training in system change for phlebotomist | 2 1 2 | National trust policy on sample taking and checking patient ID data  
Training of all staff involved in process |                  |
<table>
<thead>
<tr>
<th>Stage in process</th>
<th>No.</th>
<th>What could go wrong?</th>
<th>Causes</th>
<th>Consequences</th>
<th>Controls</th>
<th>Risk ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient wearing photo ID and details checked against documentation and verified by patient and staff on admission</td>
<td>19</td>
<td>Person taking sample relies on photo only and not ID data</td>
<td>Not aware of checking process</td>
<td>Potential for incorrect samples to be taken</td>
<td>Adequate training of staff</td>
<td>C=5 L=2 R=10</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>What if patient hasn’t got photo ID</td>
<td>Forgotten it/lost it</td>
<td>Delay in treatment</td>
<td>Default to other system — e.g. wristband</td>
<td>2 2 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Wasted resources</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>21</td>
<td>Photo not a good likeness</td>
<td>Patients appearance now different from when photo taken</td>
<td>Delay in treatment</td>
<td>Check patient data on card without relying on photo</td>
<td>2 2 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Potentially wasted resources if details not correct</td>
<td>Default to trust system — e.g. wristband</td>
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<tr>
<td>Stage in process</td>
<td>No.</td>
<td>What could go wrong?</td>
<td>Causes</td>
<td>Consequences</td>
<td>Controls</td>
<td>Risk ranking</td>
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<td></td>
<td>22</td>
<td>Details don't match documentation</td>
<td>Incorrectly recorded</td>
<td>Delay in treatment</td>
<td>Default to other system – e.g. wristband</td>
<td>2</td>
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<tr>
<td></td>
<td>23</td>
<td>Photo ID not verified</td>
<td>Complacency by staff</td>
<td>Misidentification and delay in treatment</td>
<td>Adequate training of staff</td>
<td>1</td>
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<tr>
<td></td>
<td></td>
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<td>Too busy to check</td>
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<td>Policies for admission</td>
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<td>Photo ID not available to verify</td>
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<td>Patient involvement</td>
<td></td>
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<td></td>
<td>24</td>
<td>Patient ID not checked by staff</td>
<td>Lack of knowledge</td>
<td>Potentially wrong component transfused</td>
<td>Education and training</td>
<td>5</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Not adhering to policy</td>
<td></td>
<td>Policies</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Distraction</td>
<td></td>
<td>Patient education and empowerment</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Other pressures</td>
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</table>

**Risk ranking**
- C: Critical
- L: Low
- R: Routine
<table>
<thead>
<tr>
<th>Stage in process</th>
<th>No.</th>
<th>What could go wrong?</th>
<th>Causes</th>
<th>Consequences</th>
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<th>Risk ranking</th>
<th>Solutions, ideas, recommendations</th>
<th>Actions for group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25</td>
<td>Patient ID details don't match details on blood component and/or compatibility sheet</td>
<td>Inappropriate patient identified</td>
<td>Potentially wrong component transfused</td>
<td>Stop process and start again</td>
<td>3 2 6</td>
<td>National/trust policy for blood administration and checking patient ID data</td>
<td>Stop transfusion at this stage (national guidance) and</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Potential deliberate misuse</td>
<td></td>
<td>Follow hospital procedure</td>
<td></td>
<td>Training of staff</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Incorrect labelling of blood component</td>
<td></td>
<td></td>
<td></td>
<td>Patient information and involvement in checking process – patient empowerment</td>
<td></td>
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<td></td>
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<td></td>
<td>Incorrect details on the ID card</td>
<td></td>
<td></td>
<td></td>
<td>Photo passport size and next to ID details</td>
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<tr>
<td></td>
<td>26</td>
<td>Only photo checked (over reliance on photo)</td>
<td>Complacency</td>
<td>Misidentification</td>
<td>Education and training</td>
<td>5 3 15</td>
<td>National/trust policy for blood administration and checking patient ID data</td>
<td>Photo passport size and next to ID details</td>
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<td></td>
<td></td>
<td></td>
<td>Lack of understanding</td>
<td>Photo reduces the robustness of the existing checking procedures</td>
<td>Policies</td>
<td></td>
<td>Training of staff</td>
<td></td>
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<td></td>
<td></td>
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<td>Distraction</td>
<td></td>
<td>Patient education and empowerment</td>
<td></td>
<td>Patient information and involvement in checking process – patient empowerment</td>
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<td>Other pressures</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Not following policy</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>27</td>
<td>Photo ID not worn by patient</td>
<td>Lack of understanding by patient</td>
<td>Potential misidentification</td>
<td>Stop transfusion at this stage (national guidance) and</td>
<td>1 2 2</td>
<td>National/trust policy for blood administration and checking patient ID</td>
<td>Stop transfusion at this stage (national guidance) and</td>
</tr>
<tr>
<td>Stage in process</td>
<td>No.</td>
<td>What could go wrong?</td>
<td>Causes</td>
<td>Consequences</td>
<td>Controls</td>
<td>Risk ranking</td>
<td>Solutions, ideas, recommendations</td>
<td>Actions for group</td>
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<td>C</td>
<td>L</td>
<td>R</td>
</tr>
<tr>
<td></td>
<td></td>
<td>verify patient ID</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>National/trust policy for blood administration and checking patient ID data</td>
<td></td>
</tr>
<tr>
<td></td>
<td>28</td>
<td>Patient cannot verify information</td>
<td>Patient competency could fluctuate or deteriorate</td>
<td>Minimal if policy followed for safe administration</td>
<td>Revert to hospital policy for nurse checking of all data and documentation</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Blood transfusion completed and patient discharged with photo ID</td>
<td>29</td>
<td>Photo ID left on ward</td>
<td>Lack of understanding from patient about responsibility of card</td>
<td>Potential delay before next transfusion</td>
<td>Patient information about use of card</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Inappropriately taken off patient by staff</td>
<td>Wasted resources if second card needs to be produced</td>
<td>Adequate training of staff</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>30</td>
<td>Taken by another patient</td>
<td>Confusion</td>
<td>Potential delay before next transfusion</td>
<td>Patient information about use of card</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Recklessness</td>
<td>Wasted resources if second card needs to be produced</td>
<td>Adequate training of staff</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5 – Questionnaires for pilot sites

- Pre-pilot audit form (NCBT Audit)
- Post-pilot audit form (NCBT Audit)
- Pre-pilot staff perception questionnaire
- Post-pilot staff perception questionnaire
- Patient enrolment form
- Event analysis form
Post-pilot audit form

Site code: 
Date: 

Q1  Is the patient wearing an identification wristband that contains eye-readable information?  
Yes ☐ No ☐  
If yes, continue below, if no go to Q10

Q2  If yes does it contain a readable patient’s surname?  
Yes ☐ No ☐

Q3  If yes, does it contain a readable patient’s first name?  
Yes ☐ No ☐

Q4  If yes does it contain a readable patient’s gender?  
Yes ☐ No ☐

Q5  If yes does it contain a readable patient’s date of birth?  
Yes ☐ No ☐

Q6  If yes, does it contain a readable patient ID number?  
Yes ☐ No ☐

Do the details required for Q1-Q6 match with the details on the:
Q7  Unit of blood?  
Yes ☐ No ☐

Q8  Medical records?  
Yes ☐ No ☐

Q9  Prescription sheet?  
Yes ☐ No ☐

Q10  If the patient is not wearing an eye-readable identity wristband, identify, if possible, the reasons why, using the checklist below and give details:
Please write an x in one box

- Don’t know
- Not put on by nursing staff
- Taken off by patient
- Taken off by staff and not replaced
- Patient is unable to wear an ID bracelet
- Carried by patient but not worn for transfusion
- Wristband has a barcode only
- Further details of why wristband not worn

Other reasons, please state:

Q11  Is another form of patient identification being worn instead of or in addition to a wristband?  
Yes ☐ No ☐

If yes, please select one or more from the options below or state details in the box:
ID photo (for North Midlands)
Wristband with unique number (red label)
Wristband on lanyard round neck
Other

Detected from the National Comparative Blood Transfusion Audit Report
Q6. Did you think that patients will be given sufficient information to give informed consent to participate in the pilot?
Yes [ ] No [ ]
If no please add further comments:

Q7. Do you think the patient leaflet will adequately inform patients of the key aims of the pilot and what they need to do?
Yes [ ] No [ ]
If no please add further comments:

Q8. Having read the guidance for conducting the photo ID pilot, do you think that it will be useful in terms of setting up and implementing the pilot?
Yes [ ] No [ ]
If no please add further comments:

Thank you for taking the time to complete this questionnaire.

Pre-pilot staff perception questionnaire

Hospital site code: ____________________

Staff position: ____________________

This questionnaire should be completed by the same staff who will be directly involved in the pilot before the process is introduced to the department.

The photo ID process means: taking a patient's photograph, issuing a photo ID card and collecting a patient's signature to verify likeness of photograph.

Q1. Do you think the photo ID process will be time consuming?
Yes [ ] No [ ]
If the answer to Q1 is YES please provide further details:

Q2. How effective do you think the photo ID process will be for avoiding misidentifying patients?
Please tick on the sliding scale to indicate your answer:

[ ] Very effective  [ ] No different to any other method of ID checking  [ ] Not effective

Please provide further information:
Q3. Generally, what feedback do you think you will get from patients on the photo ID card process? 

Please tick on the sliding scale to indicate your answer:

10  9  8  7  6  5  4  3  2  1  0

Please add any further comments:

Q4. How cooperative do you think patients will be with the photo ID card checking procedure? 

Please tick on the sliding scale to indicate your answer:

10  9  8  7  6  5  4  3  2  1  0

Please add any further comments:

Q5. Overall, do you think the photo ID card checking process will empower patients? 

Please tick on the sliding scale to indicate your answer:

10  9  8  7  6  5  4  3  2  1  0

Please add any further comments:

Post-pilot staff perception questionnaire

Hospital site code: 

Staff position: 

This questionnaire should be completed at the end of the pilot by the same staff who completed the pre-pilot questionnaire, and who have been directly involved in the pilot.

The photo ID process means: taking a patient’s photograph, issuing a photo ID card and collecting a patient’s signature to verify the identity of the photograph.

Please tick the boxes:

Q1. Did you consider the ID process to be time consuming? 

Yes  No

If the answer to Q1 is YES please provide further details: 

Q2. How effective do you think the photo ID process will be for avoiding misidentifying patients? 

Please tick on the sliding scale to indicate your answer:

10  9  8  7  6  5  4  3  2  1  0

Please provide further information:
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Maybe</th>
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<td>Question 9</td>
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<tr>
<td>Question 10</td>
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**Instructions:**

Please check the box that applies. Leave blank if unknown. If yes, please complete the Patient Enrollment Form.
Q2  Is this the original card you were issued with?

Yes [ ]  No [ ]

Q3  If no, Please tick the reason why your card will need to be replaced?

Card has been damaged  [ ]
Lost  [ ]
No longer a true likeness  [ ]
Details on card are no longer correct  [ ]

Thank you for taking the time to complete this form.