Get on the Bandwagon for Patient Safety

Maryland Hospital Association

MARYLAND PATIENT SAFETY CENTER
WRISTBAND TOOLKIT

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<td>Tab 12</td>
<td>Acknowledgements</td>
<td>Acknowledges the organizations and workgroup participants who assisted in the development of the “Get on the Bandwagon for Patient Safety” Implementation Toolkit.</td>
</tr>
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</table>
Tab 1: Executive Summary

Today, by adding another level of protection for Maryland patients, the Maryland Hospital Association and the Maryland Patient Safety Center are facilitating the implementation of a voluntary initiative to standardize communication for patient risk factors and special needs before patient harm occurs by defining a standard set of colors to indicate a defined set of risks.

Wristbands are commonly used for alerts such as allergy warnings, fall risks, or do-not-resuscitate orders. However, up until now, there was no standard in Maryland offering direction to hospitals as to what color identifies which alert.

After taking into account the standardization models that other states have implemented in acute care hospitals, MHA’s Council on Clinical and Quality Issues and the Maryland Patient Safety Center’s Patient Safety Officers Forum decided to adopt a model similar to those of our neighboring states, broadening patient safety efforts here in the Mid-Atlantic Region, since healthcare providers and patients often cross state borders. This consistent system will make it easier for healthcare providers across the state to identify those patients with specific health conditions.

The following chart outlines the recommendations for color-coded alert wristbands:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>RED</td>
</tr>
<tr>
<td>DNR</td>
<td>PURPLE</td>
</tr>
<tr>
<td>Fall Risk</td>
<td>YELLOW</td>
</tr>
<tr>
<td>Latex Allergy</td>
<td>GREEN</td>
</tr>
<tr>
<td>Restricted Extremity</td>
<td>PINK</td>
</tr>
</tbody>
</table>

The choice of color to designate certain conditions is not limited to wristbands. It was the unanimous recommendation of both groups that any form of designation that is used for the five (5) conditions be consistent with the colors of the wristbands. For example, if stickers or placards are used in lieu of a wristband to alert clinicians of a certain medical condition, then the stickers and placards should be consistent with the color that should be used for the wristband.

It is anticipated that the roll out process will begin in December 2009, and it is expected to take all acute care hospitals approximately one (1) year to fully implement the color coding system. A toolkit providing templates for policies and procedures, staff and educational materials, vendor specifications and other additional materials will be accessible via the Maryland Patient Safety Center Website.

For more information, visit www.marylandpatientsafety.org.
Executive Summary

Purpose
Without standardization of colors and the clinical conditions they are used to designate, the use of colored patient wristbands may pose a patient safety risk to your organization and patients. Risk exists because various healthcare settings use non-standardized colors for wristbands and healthcare professionals often work at more than one healthcare setting. This may lead to confusion and error.

Maryland is embarking on an innovative process of voluntary standardization of wristband colors.

Poor communication is a leading contributing factor to adverse events that occur in healthcare settings. One way to improve communication is to standardize color coding for “alert” wristbands within broad geographic areas. Standardized colors and messages displayed on wristbands provide consistent and continuous communication within a healthcare setting and between healthcare facilities.

“Get on the Bandwagon FOR PATIENT SAFETY” establishes standardized guidelines for the use of red, yellow, green, pink and purple wristbands for voluntary implementation by Maryland hospitals.

This toolkit offers a robust set of resources designed to help your organization participate in the patient colored wristband standardization process. With support and input from a wristband workgroup, the Maryland Hospital Association and the Maryland Patient Safety Center are pleased to offer these resources to Maryland hospitals and long term care organizations. We hope your organization will “Get on the Bandwagon FOR PATIENT SAFETY” through this endeavor.

We recognize that this process will require approximately one year to be completely implemented, and as such, we have included a work plan as a guide to assist you in keeping on target as you move forward. Contact information of those individuals who can most assist can be found on the last page of this toolkit, and we are available to assist you in any way possible.
Background
In December 2005, the Pennsylvania Patient Safety Authority issued a patient safety advisory that received national attention. This advisory brought attention to an incident in a Pennsylvania hospital in which clinicians nearly failed to rescue a patient who had a cardiopulmonary arrest because the patient had been incorrectly designated as Do Not Resuscitate (DNR).

The source of confusion was a nurse who incorrectly placed a yellow wristband on the patient. In that hospital a yellow wristband meant DNR. In a nearby hospital, where the nurse also worked, yellow meant “restricted extremity” which was what she intended to indicate by placing the colored wristband on the patient. Fortunately, in this case, another nurse recognized the mistake and the patient was resuscitated.

In response to this incident, Pennsylvania hospitals and ambulatory surgery centers were surveyed, revealing that 78 percent of the facilities use color-coded patient wristbands to communicate important medical information and that no standard meaning for the different colors existed among healthcare facilities. Allergies, fall risk and restricted extremity were the most common conditions for which colored wristbands were used. Pennsylvania became the first state in the nation to implement voluntary guidelines for standardization of colored wristbands for six clinical conditions (allergy-red, fall risk-yellow, latex allergy-green, DNR-blue, patient identification-clear and limb alert-pink). Immediately following in Pennsylvania’s footsteps were Arizona, Iowa, Michigan, Minnesota, Florida, Colorado, New Jersey, just to name a few, all of which initiated the effort to standardize communication for patient risk factors and special needs before patient harm occurs.

MHA’s Council on Clinical and Quality Issues, as well as the Maryland Patient Safety Center’s Patient Safety Officers Forum, supported adoption of the standardized wristband colors designating a defined set of patient safety risks. A Work Group was established to develop implementation guidelines, and provide recommended resources and tools for hospitals and other healthcare facilities. The Work Group also stressed the importance of reaching out to the continuum of care including all types of hospitals, long-term care facilities, ambulatory care centers and home health providers, as well as the professional organizations representing the facilities and the professions involved. This expert panel:

1. Identified the priority risk categories for patients across the continuum of care;
2. Reached consensus on standardized color definitions of wristbands;
3. Developed a work plan and created a comprehensive implementation toolkit for providers to use to adopt the standardization of color coded wristbands; and
4. Recommended that healthcare organizations consider everyone involved in the system of care process; i.e.:

- Environmental Services staff is often present in a patient room when a patient is trying to get up or is walking to the bathroom. If they know a yellow wristband means “Fall Risk,” and they see a patient trying to get up, they can call the nursing staff, alert them and potentially prevent a fall.

- Consider the dietary technicians. A red wristband means there is an allergy — and not just to medications. A red band will alert dietary staff to check a patient’s profile for potential food allergies.

- All medical staff, including attendings, intensivists, hospitalists, residents and interns, should be included in the change process.

**Recommended Action**

Based on knowledge of the Pennsylvania incident, and knowing more than half of all the states across the country have adopted and/or implemented similar programs delineating specific, standardized colors for identifying certain patient conditions, Maryland hospitals, with endorsement from the Maryland Hospital Association and the Maryland Patient Safety Center (MPSC), are voluntarily adopting the use of the following standardized colors:

<table>
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Of note, all of Maryland’s neighboring states have adopted voluntary colored wristband standardization policies.

**This Toolkit**

The wristband Implementation Toolkit supports the “*Get on the Bandwagon FOR PATIENT SAFETY*” initiative. It contains a full set of informative resources, model policies, sample tools and educational materials that will help your organization roll out a wristband standardization program. In addition, hospitals will be asked to periodically report their implementation progress back to the Maryland Patient Safety Center for tracking and reporting purposes.
The Maryland Hospital Association and the Maryland Patient Safety Center would like to acknowledge appreciation to the following organizations for allowing the utilization of the resources in this toolkit, which have been adapted for use by Maryland health care organizations:

The Arkansas Hospital Association
The Arizona Hospital Association
The Connecticut Hospital Association
The Florida Hospital Association
The Kansas Hospital Association
The Illinois Hospital Association
The New Jersey Hospital Association
The Michigan Hospital Association
The Minnesota Hospital Association
The Missouri Center for Patient Safety
Foundation for Healthy Communities (New Hampshire)
The Pennsylvania Patient Safety Authority
The Virginia Hospital and Healthcare Association
The Washington Hospital Association
The West Virginia Hospital Association

For more information, the following Websites contain additional materials and resources about the standardization of color-coded alert patient safety wristbands:

http://www.arkhospitals.org/wristbandtoolkit.htm
http://www.fha.org/wristband.html
http://www.mocps.org/initiatives/Banding_ToolKit.pdf
http://www.wvha.com/patient_safety/index.htm
Tab 2: Frequently Asked Questions About Wristband Color Standardization

Purpose: This document was designed to address key questions about the colors selected for wristband standardization, as well as questions about implementation. You may adapt this information for use in your facility.

We will update and revise the FAQ’s as we move forward.
Maryland’s Frequently Asked Questions About Wristband Standardization

Q. Is there any national standard for the use of colored wristbands?

A. There is no national activity or movement toward regulating or mandating the standardization of colored wristbands, nor is implementation required. However, the American Hospital Association, in conjunction with the American Society for Healthcare Risk Management, published a Quality Advisory on September 4, 2008, entitled, “Implementing Standardized Colors for Patient Alert Wristbands,” asking all hospitals to consider voluntarily using three standardized colors for alert wristbands. The colors, which were originally adopted as a consensus in numerous states, are:

- red for patient allergies;
- yellow for a fall risk; and
- purple for do-not-resuscitate patient preferences.

Currently more than half of all of the states in the country have implemented 2–5 standard colors. Maryland’s neighboring states, including Virginia (3); Pennsylvania (5), Delaware (to be announced), West Virginia (3), and New Jersey (5) have all adopted color coded wristband standardization programs.

Q. Who decided on these colors?

A. These colors have already been adopted by our neighboring states. Additionally, research in Pennsylvania, Arizona, Missouri, other industries and the science of human factors all were considered in making the recommendations. Subsequently, MHA, the MPSC and other advisors agreed on the need for voluntary standards to decrease the risk to patients from potential misinterpretation of wristband colors.

Q. When does our facility need to implement these colors?

A. This program is being disseminated to all healthcare entities in mid-December 2009, and it is anticipated that the implementation process will take approximately one (1) year. A status report will be requested from each participating facility approximately six (6) months after the program has been introduced to determine if additional time to completely implement the program is needed.
Q. If our facility does not currently use wristbands, do we have to implement them, or can we use our own tools?

A. If your organization has not adopted colored-coded alert wristbands, it is not necessary for your hospital to adopt them now, although adopting the color-coded system is recommended.

RED – ALLERGY ALERT

Recommendation:
Hospitals adopt the color **RED** for Allergy Alert wristbands, embossing or printing them with the words “Allergy Alert” or “Allergy.”

Q. Why was red selected for allergy alert?

A. Red was selected because all of Maryland’s neighboring states already use it to designate allergy to medications and/or specific foods. Therefore, it makes the most sense to continue with this established color that is already being used and is beginning to become a national standard to designate allergy.

Additionally, research of other industries reveals that red is associated with extreme concern. The American National Standards Institute (ANSI) has designated certain colors with very specific warnings. ANSI uses red to communicate “Stop!” or “Danger!” This message should hold true for communicating an allergy status. When caregivers see a red allergy alert band, they are prompted to “Stop!” and double check if the patient is allergic to the medication, food, or treatment they are about to receive.

Q. Do we write the actual allergy the patient has on the wristband too?

A. It is recommended that additional information about the actual allergy be written in the medical record according to your hospital’s policy and procedure. It is recommended that actual allergies NOT be written on the wristband for several reasons:

* Legibility may hinder the correct interpretation of the allergy written on a wristband.
* It may be assumed that allergies written on the wristband are comprehensive. However, space is limited on wristbands, and some patients may have in excess of 12 or more allergies; therefore there is a risk that some allergies could be omitted inadvertently, leading to confusion or a missed allergy.
* Throughout a hospitalization, allergies may be discovered by other caregivers, such as dieticians, radiologists, pharmacists, etc. This information typically is added to the medical record and not always a wristband. With one source of
comprehensive information about all allergies to refer to, such as the medical record, all staff will know where to add and find newly discovered allergies. The wristband will continue to serve as an “alert” to all staff about an allergy.

**Q. Does this mean we can no longer use Red or “R” on bands to designate blood bank information?**

A. No, although it is important to educate staff thoroughly about the difference between your current blood bank bands and any newly implemented red bands to designate allergies. This is another reason text is recommended to be placed on the Red bands to designate “Allergy Alert” or “Allergy” as another way to differentiate these two bands. The product decision made by your hospital should consider the style and hue of red that may be used for current blood bank wristbands and make sure new products implemented to designate allergy are differentiated easily from the blood bank bands.

**FALL RISK – YELLOW**

**Recommendation:**
It is recommended that hospitals adopt the color YELLOW for Fall Risk Alert wristbands, embossing or printing them with the words “Fall Risk.”

**Q. Why is yellow recommended to designate fall risk?**

A. Research reveals yellow is associated with “Caution!” such as traffic lights – to proceed with caution or stop altogether. The American National Standards Institute (ANSI) has designated certain colors with very specific warnings. ANSI uses yellow to communicate “Tripping or Falling Hazards.” This fits well in healthcare as well when associated with a fall risk. Caregivers would want to be alert to and use caution with a person who has history of falls, dizziness, balance problems, fatigability or confusion about their current surroundings. Pennsylvania also selected yellow, an established color already being used and becoming a national standard to designate fall risk.

**Q. Why use an alert band for fall risk?**

A. According to data from the Maryland Patient Safety Center, the Office of Healthcare Quality and the Centers for Disease Control and Prevention (CDC) falls are an area of great concern in the aging population.

* In Maryland, through FY 2008, Falls was the second most frequently reported incident.
* In Maryland, through FY 2008, almost 25% of patients who fell in healthcare facilities sustained an injury.
* In Maryland, deaths resulting from falls in healthcare facilities were the most frequently reported serious adverse event to the Office of Healthcare Quality.
More than a third of adults aged 65 years or older fall each year.
Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes.
Of those who fall, 20-30% suffer moderate to severe injuries that reduce mobility and independence and increase the risk of premature death.
The total cost of fall injuries for people aged 65 or older in 1994 was $27.3 billion (in current dollars).
By 2020, the cost of fall injuries is expected to reach $43.8 billion (in current dollars).
Hospital admissions for hip fractures among people over age 65 have increased steadily from 230,000 admissions in 1988, to 338,000 admissions in 1999.
The number of hip fractures is expected to exceed 500,000 by the year 2040.
As the aging population enters the acute care environment, one must consider the risk that is present and do everything possible to communicate that to hospital staff.

**PURPLE - DO NOT RESUSCITATE**

**Recommendation:**
Hospitals adopt the color **PURPLE** for Do Not Resuscitate wristbands, embossing or printing them with the letters “DNR.”

**Q. My hospital doesn’t use wristbands for DNR. Why should we consider adopting this guideline?**
A. While most Maryland hospitals use wristbands to communicate an alert, which have been very helpful to contracted or agency staff (i.e., registry staff, traveling staff, non-clinical staff, etc) who may be unaware of where to look in the medical record if they are new to your hospital, or workers may work at another facility where wristbands are used. By having a wristband on, a quick warning is communicated. The wristband also is a way to demonstrate to the family clear communication about end-of-life wishes.

Also, if a patient is transferred between units, departments, or to other facilities, a band is a quick communication about the patient’s end-of-life wishes should anything happen to the patient when not on his/her home unit. By not having a band on, errors of omission potentially could occur.

However, if your organization has not adopted colored-coded alert wristbands, it is not necessary for your hospital to adopt them now, although adopting the color-coded system is recommended.
Q. Why not use Blue to designate DNR?
A. The work performed in Pennsylvania, where blue is used to standardize DNR, and Arizona and its surrounding five states, where purple is used to standardize DNR, was considered. The Missouri survey reveals 38 percent of respondents use “blue” to designate “DNR” and 29 percent use some shade of purple, with others using red, yellow, orange, or green. It is also common for a “Code Blue” to be called in hospitals when a patient requires resuscitation. If a blue wristband designates “no code” and a “Code Blue” is called to resuscitate a patient, confusion could exist in whether the blue band means to code or not to code. To avoid creating any second-guessing in this situation, the decision was made to adopt the same guideline as in the Southwestern states - purple.

Q. Why not green to designate DNR?
A. Green appears to be used by a number of Maryland hospitals for DNR, which was considered when these recommendations were made. However, green was avoided due to color blindness concerns. Also, the color green often means “Go Ahead,” such as with traffic lights. Therefore, to avoid any possibility of communicating the wrong message the decision was made not to recommend the use of green.

Q. If we adopt the purple DNR wristband, do we still need to look in the chart?
A. Yes. Some hospitals do not use wristbands for DNR because they want the chart to be reviewed first for the most current code designation. However, review of the chart should be the practice in all cases, whether a wristband is being used or not. Code status can change throughout a hospitalization. It is important to know the current status so the patient’s and family’s wishes can be honored.

Q. How will the guideline to use purple to designate DNR in a hospital setting coordinate with potential future designation for out-of-hospital DNR?
A. Maryland hospitals will make every effort to coordinate implementation of any new voluntary, standardized guidelines being used by hospitals with all other healthcare settings, to keep the continuum of care as consistent as possible.

Q. How does this initiative coordinate with regional disaster planning groups in the state that are implementing standardized red, yellow, and green triage and tracking bands for use on patients in the field and for ambulance transportation?
A. In the case of an incident involving multiple patients, pre-hospital EMS providers in Maryland first designate the severity of injuries or illness by tying a colored ribbon (Red, Yellow, Green or Black surveyor’s tape) on the upper arm of the patient. That is followed up with a triage tag (4”X8”) being tied to the ribbon. These tags contain specific treatment and demographic information about that patient. Some hospitals do leave the ribbons in place during the initial phases of in-hospital care, but with minimal familiarization there should be no confusion between the two identification systems.
The ribbons are clearly distinguishable between the typical arm bands that are part of the Wristband initiative. In addition, the bands used for this project will include text that easily signifies the specific “alert” the band designates. Therefore, the Wristband initiative should not conflict with regional disaster planning banding procedures; however, hospitals are encouraged to be aware of any such procedures that are occurring within their region.

**PINK – RESTRICTED EXTREMITY**

**Recommendation:**
It is recommended that hospitals adopt the color **PINK** for the restricted extremity alert designation with the words “RESTRICTED EXTREMITY” printed on the wristband.

**Q. On which extremity should the restricted extremity band go?**
A. The restricted extremity band should be placed on the affected extremity. This alert wristband also can be placed on the extremity that should not be used for blood pressure measurement, IV insertion or other medical procedures secondary to certain medical conditions such as previous history of breast cancer or lymph edema.

**GREEN – LATEX ALLERGY**

**Recommendation:**
It is recommended that hospitals adopt the color **GREEN** for the latex allergy alert designation with the words “LATEX ALLERGY” printed on the wristband.

**Q. Why was green selected?**
A. Green was selected due to the color having a close association with the environment. Although many hospitals may not necessarily use a separate band for latex allergy, many facilities may use another form of designation to alert hospital staff, including a sticker on the chart or placard outside of the patient’s hospital room. The recommendation for standardization of color extends beyond wristbands to include any form of designation that is associated with a medical condition. The purpose of the recommendation for latex allergy is to provide a standard color **(green)** for healthcare providers, which can be easily identified and readily associated with allergies to latex.
Tab 3: Hospital Wristband Work Plan

Purpose: This is a model work plan to guide successful implementation of the standardized wristband colors, including education, wristband selection and purchase and community outreach. The work plan should be adapted and updated to apply to each organization.
## Hospital Wristband Work Plan

<table>
<thead>
<tr>
<th>Area</th>
<th>Rationale</th>
<th>Action Plan</th>
<th>Completion Date/Responsible Staff (To be assigned)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase I</strong> Organizational Approval and Awareness</td>
<td>Should take approximately 2 mos</td>
<td>To gain support for the initiative, identify all stakeholders. Seek their approval and understanding of the initiative before implementation.</td>
<td>Identify which committees need to be aware of and/or approve this new initiative.</td>
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<td>Get on the agenda for each of these committees.</td>
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<td>Provide information for the hospital newsletters, postings in elevators, etc.</td>
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<tr>
<td><strong>Phase IIa. Wristband Selection and Purchase</strong></td>
<td>Should take approximately 3-6 mos</td>
<td>Coordinate with Materials Management Department to evaluate current banding products used, current stock levels, obtaining different products, and implementation timeline.</td>
<td>Contact Materials Management Department to determine the current type of wristbands used and current supply.</td>
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<td>Implementation of this initiative should be coordinated with your Materials Management Department to evaluate when current stock will be used up, to make decisions about any necessary new supplies, and to coordinate the timeline for full implementation of the initiative.</td>
<td>Communicate with current vendor(s) of wristbands about the hospital’s implementation of this initiative.</td>
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<td>Identify options for obtaining new wristbands, if necessary, to implement the initiative. (See “Banding Products” section of this toolkit).</td>
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<td>Have committees/individuals, as appropriate in your hospital, review vendor options for wristbands to make a decision regarding procurement.</td>
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<td>Order new wristbands as necessary, determining when the supply will be available to determine the “roll-out” date of the initiative</td>
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<td>Coordinate “roll-out” with appropriate departments that need to be aware of the implementation of the initiative.</td>
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<tr>
<td>Phase II b, Hospital Specific Documentation</td>
<td>Should take approximately 3-6 mos</td>
<td>Coordinate with clinical leadership, medical record committees, and/or form committees to determine what current documentation contains specific information about wristbands.</td>
<td>$90-120$ days To do concurrently with the band selection and ordering process in previous item - thus within that 3-6 month timer frame noted for that item</td>
</tr>
<tr>
<td>Concurrent with Band Selection, coordinate policy and procedure form reviews with clinical departments, as well as all other appropriate departments.</td>
<td>The new initiative and applicable policies and procedures should be reviewed and compared to current banding policy. Forms (such as patient education assessment, ED triage records or treatment notes, admitting assessment, ICU nurses notes, preoperative assessment/notes, daily nursing documentation) should be reviewed and revised as necessary to comply with the policy. Human Resource policies addressing employee requirements for wearing social cause items should be reviewed, as applicable, to correlate with this initiative.</td>
<td>If current documentation addresses wristband information, make sure references to colors are updated to reflect the new initiative. If changes are required, obtain approval as necessary through appropriate committees and communication processes. If form changes are necessary, factor into the implementation timeline the time to print, provide education, and implement the new forms. Review current policies and procedures for wristband application and applicable human resource policies. Update as necessary for the new initiative. A Policy and Procedure template is provided in this toolkit. Contact the clinical department directors to identify any department-specific policies for banding, and implement changes as necessary. Obtain approval of department-specific or hospital-wide policies through the appropriate committees.</td>
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<td><strong>Phase III a. Staff Orientation and Training</strong></td>
<td>Should take approximately 2 mos</td>
<td>Review the resources provided in this toolkit for use in staff training, i.e.: 1. Training Tips 2. Competency checklist template 3. Staff brochure 4. Patient brochure 5. FAQ's 6. PowerPoint presentation</td>
<td><strong>60 days</strong></td>
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<td>Coordinate implementation with hospital education staff.</td>
<td>Work with the Education Department and Clinical Directors to determine the format, such as unit-specific, general sessions, Web-based, etc., for providing education about this new initiative. Work with the Education Department and Clinical Directors, as appropriate, to make sure the colored wristband policy is included in general orientation sessions. Determine who will facilitate the education, such as individual clinical directors, the Education Department, the champion for this initiative, etc. Use the tools available in this toolkit, modified for your particular needs. Coordinate the “roll-out” schedule to allow all education and training to be completed prior to “roll-out”. Coordinate &quot;roll-out&quot; with appropriate departments that need to be made aware of the initiative. Maintain documentation of training and attendance.</td>
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Get on the Bandwagon for Patient Safety
December 2009
## Hospital Wristband Work Plan

<table>
<thead>
<tr>
<th>Area</th>
<th>Rationale</th>
<th>Action Plan</th>
<th>Completion Date/Responsible Staff (To be assigned)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase III b. Patient Education</strong>&lt;br&gt;&lt;br&gt;Should take approximately 2 mos</td>
<td>It is important for patients and their families to be aware of the colored wristband policy and be involved in their use.</td>
<td>Review and use the resources provided in this toolkit for patient education. They can be modified for your use, including incorporating your logo on the brochure.&lt;br&gt;1. Components of patient education&lt;br&gt;2. Patient brochure&lt;br&gt;Work with the Education Department and Clinical Directors to coordinate patient education activities.&lt;br&gt;Work with any committees that review and approve patient education materials prior to implementation.&lt;br&gt;Coordinate the “roll-out” schedule to allow all education materials to be available and incorporated into admission processes prior to roll-out. Make sure documentation of the patient/family education is provided and complies with hospital policy.</td>
<td>60 days Run most of this one currently with staff education as far as planning for patient education. The roll-out to staff on this aspect can then be part of their education.</td>
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## Hospital Wristband Work Plan

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<td><strong>Phase IV. Community Education</strong></td>
<td>Should take approximately 1 mo</td>
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<td>Review the resources provided in this toolkit for community education.</td>
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<tr>
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<td>1. Stakeholder contacts</td>
<td>30 days Planning for community notice should be done concurrently with the planning for staff and patient education, but not be announced to the public until well underway within the hospital.</td>
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<td></td>
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<td>2. Charitable organization draft letter</td>
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<td></td>
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<td>3. Healthcare provider draft letter</td>
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<td></td>
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<td>4. Poster</td>
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<td>5. PowerPoint presentation</td>
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<td></td>
<td>6. Draft press release</td>
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<td></td>
<td>Coordinate implementation with public relations and community liaisons, engaging other providers to implement the standardized recommendations, as appropriate.</td>
<td>Work with Public Relations and/or Community Relations to coordinate messages for the public. These may include newspaper articles, letters to community organizations, and letters to healthcare providers.</td>
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<td>Implementation of this initiative communitywide may be an opportunity to show the public how healthcare providers can work together to improve patient safety.</td>
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<td></td>
<td>Coordinate the “roll-out” schedule to allow sufficient communication within the community about this initiative.</td>
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Overall, estimate a 10-month process, or to allow for any obstacles (usually a 12 month timeline for this process).
Purpose: A sample policy and procedure template is provided that addresses the colors of the Maryland “Get on the Bandwagon for Patient Safety” initiative.

The Policy and Procedure will need to be adapted and individualized for your organization. In addition, your organization may have complementary policies and procedures that will need to be updated for consistency with the Maryland colors. Please review and revise the complementary policies and procedures as noted in the sample work plan.
Policy and Procedure Template

Policy name: Color-coded Wristbands

Purpose
To have a standardized process that identifies and communicates patient-specific risk factors or special needs by standardizing the use of color-coded wristbands based upon the patient’s assessment, wishes, and medical status.

Objectives

A. To reduce the risk of confusion associated with the use of color-coded wristbands.
B. To communicate patient safety risks to all healthcare providers.
C. To include the patient, family members, and significant others in the communication process and promote safe healthcare.
D. To adopt the following risk reduction strategies:

1. A preprinted written descriptive text is used on the bands clarifying the intent (i.e., “Allergy,” “Fall Risk,” “DNR,” “Latex Allergy,” or “Restricted Extremity”).
2. Except in emergent situations, no handwriting is used on the wristband.
3. Colored wristbands may only be applied or removed by a nurse or licensed staff person conducting an assessment.
4. If labels, stickers, or other visual cues are used in the medical record to communicate risk factors or wristband application, those cues should use the same corresponding color and text to the colored band.
5. Social cause wristbands, such as the “Live Strong” and other causes, should not be worn in the hospital setting. Staff should have family members take the social cause wristbands home or remove them from the patient and store them with his/her other personal items. This is to avoid confusion with the color-coded wristbands and to enhance patient safety practices.
6. To involve the patient and his/her family members as a partner in the care provided and safety measures being used, patient and family education should be conducted regarding:

i. The meanings of the hospital wristbands and the alert associated with each wristband; and

ii. The risks associated with wearing social cause wristbands and why they are asked to remove them.

Definitions

The following represents the meaning of each color-coded band:

**Band Color Communicates:**

- **Red Allergy**
- **Yellow Fall Risk**
- **Purple DNR**
- **Green Latex Allergy**
- **Pink Restricted Extremity**

**Identification (ID) Bands in Admission, Pre-Registration Procedure, and/or Emergency Department**

The colorless or clear admission ID wristbands are applied in accordance with procedures outlined in organizational policy on patient ID and registration. These ID bands may be applied by non-clinical staff in accordance with organizational policy.

**Color-coded “Alert” Wristbands**

During the initial patient assessment, staff collects data to evaluate the needs of the patient and a plan of care unique to the individual is initiated. Throughout the course of care, reassessment is ongoing and may uncover additional pertinent medical information, trigger key decision points, or reveal additional risk factors about the patient. It is during the initial and reassessment procedures that risk factors associated with falls, allergies, and DNR status are identified or modified. Because this is an interdisciplinary process, it is important to identify who has responsibility for applying and removing color-coded wristbands, how this information is documented, and how it is communicated. The following procedures have been established to remove uncertainty in these processes:
A. Any patient demonstrating risk factors on initial assessment will have a colored band placed on the same extremity as the admission ID band by the nurse or licensed professional, if the nurse is unavailable.

B. The application of the band is documented in the chart by the nurse, per hospital policy.

C. If labels, stickers, or other visual cues are used to document in the record, the stickers should correspond to wristband color and text.

D. Upon application of the colored wristband, the nurse will instruct the patient and his/her family member(s) (if present) that the wristband is not to be removed.

E. In the event that any color-coded wristband has to be removed for a treatment or procedure, a nurse will remove the wristband. Upon completion of the treatment or procedure, a new wristband will be made, risks reconfirmed, and the wristband reapplied immediately by the nurse. This same procedure applies if more than one colored wristband is involved.

Social Cause Wristbands

Following the patient ID process, a licensed clinician, such as the admitting nurse, examines the patient for “social cause” wristbands. If social cause wristbands are present, the nurse will explain the risks associated with the wristbands and ask the patient to remove them. If the patient agrees, the wristband will be removed and given to a family member to take home, or stored with the other personal belongings of the patient. If the patient refuses, the nurse will request the patient sign a refusal form acknowledging the risks associated with the social cause wristbands (see attached document). In the event that the patient is unable to provide permission, and family member(s) or a significant other is also not present, the licensed staff member may remove the wristband(s) in order to reduce the potential of confusion or harm to the patient.

Patient/Family Involvement and Education

It is important that the patient and family members are informed about the care being provided and the significance of that care. It is also important that the patient and his/her family member(s) be acknowledged as a valuable member of the healthcare team. Including them in the process of color-coded wristbands will assure a common understanding of what the wristbands mean, how care is provided when the wristbands are worn, and their role in correcting any information that contributes to this process. Therefore, during assessment procedures, the nurse should take the opportunity to educate and re-educate the patient and his/her family members about:
A. The meanings of the hospital wristbands and the alert associated with each wristband;

B. The risks associated with wearing social cause wristbands and why they are asked to remove them;

C. Notification of the nurse whenever a wristband has been removed and not reapplied, or when a new wristband is applied and they have not been given explanation as to the reason.

D. A patient/family education brochure (see attached), that explains this information, is also available to patients and family members.

**Hand-off in Care**

The nurse will reconfirm color-coded wristbands before invasive procedures, at transfer, and during changes in level of care with patient/family, other caregivers, and the patient’s chart. Errors are corrected immediately. Color-coded wristbands are not removed at discharge. For home discharges, the patient is advised to remove the wristband at home. For discharges to another facility, the wristbands are left intact as a safety alert during transfer. Receiving facilities should follow their policy and procedure for the banding process.

**DNR (Do Not Resuscitate)**

DNR status and all other risk assessments are determined by individual hospital policy, procedure, and/or physician order written within and acknowledged within that care setting only. The color-coded wristband serves as an alert and does not take the place of an order. Do Not Resuscitate orders must be written and verification of Advanced Directives must occur.

**Staff Education**

Staff education regarding color-coded wristbands will occur during the new orientation process and be reinforced as indicated.

*(Note to Hospitals: You should insert your specific language in this section so it matches your annual processes and competencies, should you decide to include color-coded wristbands in that process.)*
Patient Refusal

If the patient is capable and refuses to wear the color-coded wristband, an explanation of the risks will be provided to the patient/family. The nurse will reinforce that it is the patient’s and his/her family’s opportunity to participate in efforts to prevent errors, and it is the patient’s and his/her family’s responsibility as part of the team. The nurse will document in the medical record patient refusals, and the explanation provided by the patient or his/her family member. The patient will be requested to sign an acknowledgement of refusal by the completion of a release.
Patient Refusal to Participate in the Wristband Process

Patient Identifier Information

Name: ________________________________

PID: ________________________________

DOB: ________________________________

Admitting

The above named patient refuses to: (check what applies)

☐ Wear color coded alert wristbands.

The benefits of the use of color coded wristbands have been explained to me by a member of the healthcare team. I understand the risk and benefits of the use of color coded wristbands, and despite this information, I do not give permission for the use of color coded wristbands in my care.

☐ Remove “Social Cause” colored wristbands (like “Live Strong” and others).

The risks of refusing to remove the “Social Cause” colored wristbands have been explained to me by a member of the health care team. I understand that by refusing to remove the “Social Cause” wristbands could cause confusion in my care, and despite this information, I do not give permission for the removal of the “Social Cause” colored wristbands.

Reason provided (if any): ________________________________

____________________________________________________

Date / Time Signature / Relationship

____________________________________________________

Date / Time Witness Signature / Job Title

MHA and MPSC wish to acknowledge the AzHHA and the Pennsylvania Color of Safety Task Force, which developed the initial format that is the basis for this document.

Maryland Hospital Association
Tab 5: Sample staff education, competency assessment and communication tools

Purpose: This tab contains a useful set of tools for staff education and awareness raising. These tools are intended for adaptation to your clinical setting. The tools include:

1. Sample staff education brochure
2. Sample Quick Reference Card
3. Sample staff education PowerPoint Presentation with teaching notes
4. Staff competency assessment

Please feel free to add your hospital logo to the materials if you desire.
How this all got started...

In 2005, a hospital in Pennsylvania submitted a report to the Pennsylvania Patient Safety Reporting System (PA-PSRS), describing an event in which clinicians nearly failed to rescue a patient who had a cardiopulmonary arrest because the patient had been incorrectly designated as “DNR” (do not resuscitate). The source of the confusion was that a nurse had incorrectly placed a yellow wristband on the patient. In this hospital the color yellow signified “restricted extremity”, meaning that this arm is not to be used for drawing blood, blood pressure readings or obtaining IV access. Fortunately, in this case, another clinician identified the mistake and the patient was resuscitated. However, this “near miss” highlights a potential source of error and an opportunity to improve patient safety by re-evaluating the use of color-coded wristbands.

We want to thank and acknowledge this hospital for their transparency and disclosure of this event. It could have happened anywhere, and it has served as a wake-up call to many of us.

What about Maryland?

The Maryland Hospital Association and the Maryland Patient Safety Center responded to the AHA Member Alert published in September 2008 endorsing color-coded alert wristbands by asking hospitals to voluntarily commit to following more than one half of all the states across the country in adopting these colors, particular when all of our neighboring states have already done so.

The Big Picture

This initiative is being adopted here in Maryland, as well as in all of the Mid-Atlantic states located within this region, which includes Virginia, Delaware, Pennsylvania, New Jersey and West Virginia, and all are united in this effort. That means that whether you are traveling on vacation or relocating to any of these states, most of the hospitals in this region of the country will be consistent in being aware of and knowledgeable about the medical conditions for which wristbands may need to be applied.

RED means “ALLERGY ALERT”
YELLOW means “FALL RISK”
PURPLE means “DNR”
GREEN means “LATEX ALLERGY”
PINK means “RESTRICTED EXTREMITY”

Staff Education Regarding:

Color-coded “alert” wristbands

Information intended for all staff, clinical and non-clinical.
**Color-coded Alert Wristbands – A Maryland Patient Safety Initiative**

Maryland’s initiative is based on knowledge of the Pennsylvania incident in which clinicians nearly failed to resuscitate a patient who had a cardiopulmonary arrest because the patient had been incorrectly designated as DNR. Additionally, more than half of all of the states across the country have adopted standardized colors for identifying certain patient conditions.

**Standardize for Patient Safety**

Standardize the colors being used for Allergies, Fall Risk, DNR, Latex Allergy and Restricted Extremity in all Maryland healthcare organizations (hospitals, home health, skilled nursing facilities, hospice organizations, etc.).

**How to tell patients what the different colors mean**

*How* we say something is just as important as *what* we say. The next column is a script you can use to tell your patients and families about the color-coded alert wristbands and what they mean. If everyone says the same thing, in the same manner, using the same language, there is a better chance patients and families will understand what we are saying.

**SCRIPT**

**For any staff person talking to a patient or family**

*What do the colors mean?*

There are five different color-coded “alert” wristbands that we are going to discuss because they are the ones most commonly used.

**RED means ALLERGY ALERT**

If a patient has an allergy to anything, such as food, medicine, dust, grass, pet hair, or ANYTHING at all, please tell us. It may not seem important to you, but it could be very important in the patient care received.

**YELLOW means FALL RISK**

We want to prevent falls at all times. Nurses review patient information all the time to determine if a patient may need extra attention in order to prevent a fall. Sometimes, patients become weakened during their illness or because they just had surgery. When a patient has this color-coded wristband, the nurse is saying this person needs to be assisted when walking or they may fall.

**PURPLE means DNR or Do Not Resuscitate**

It is important we honor a patient’s wishes for end-of-life care.

**GREEN means LATEX ALLERGY**

Some patients are specifically allergic to latex and there are alternative products caregivers can use. We want to assure a safe environment for our patients, and it can be as simple as using latex free products.

**PINK means RESTRICTED LIMB**

Sometimes a patient’s arm shouldn’t be used for taking a blood pressure reading, drawing blood or inserting an IV. This band tells us to be sure we use the correct arm.

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**Other Risk Reduction Strategies Staff Should Know**

**Risk Reduction Strategies Quick Reference Card**

1. Use wristbands with alert messages pre-printed on the bands.
2. Remove all “social cause” colored wristbands (i.e., “Live Strong”)
3. Remove wristbands that have been applied at another facility.
4. Initiate banding upon admission, changes in condition or when updated information becomes available.
5. Educate patients and family members about use and purpose of wristbands.
6. Coordinate chart/white board/care plan/stickers/placards with same color coding as wristbands.
7. Educate staff to verify patient alerts and wristbands upon assessment, hand-off or care during shift change, transfer to another unit or facility and at discharge.
8. Remember, the wristband is a tool to communicate an alert status, so make sure staff is educated to always utilize the patient’s medical record for verification of allergies, fall risk, advance directives, latex allergies and restricted limb use.
## Recommendation: Risk Reduction Strategies

<table>
<thead>
<tr>
<th>Risk Reduction Strategies</th>
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<tbody>
<tr>
<td><strong>Color-coded “Alert” Wristbands/Risk Reduction Strategies Quick Reference Card</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1. Use wristbands that are pre-printed with text that tells what the band means.</strong></td>
<td><strong>5. Educate patients and family members regarding the wristband.</strong></td>
</tr>
<tr>
<td>a. This can reinforce the color coding system for new clinicians, help caregivers interpret the meaning of the band in dim light, and also help those who may be color blind.</td>
<td>a. Including the family in this is a safeguard for you and the patient.</td>
</tr>
<tr>
<td>b. Eliminates the chance of confusing colors with alert messages.</td>
<td>b. Remind them that color coding provides another opportunity to prevent errors.</td>
</tr>
<tr>
<td>2. Remove any “social cause” (such as Live Strong, Cancer, etc.) colored wristbands.</td>
<td>c. Use the Patient / Family Education brochure located in the toolkit bands.</td>
</tr>
<tr>
<td>a. Be sure this is addressed in your hospital policy.</td>
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<tr>
<td>b. If that can’t be done, you can cover the band with a bandage or medical tape, but removal altogether is best.</td>
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<tr>
<td>3. Remove wristbands that have been applied from another facility.</td>
<td><strong>6. Coordinate chart/white board/care plan/door signage information/stickers with same color coding.</strong></td>
</tr>
<tr>
<td>a. This should be done during the entrance to facility process and/or admission.</td>
<td>a. For allergies, fall prevention and DNR status.</td>
</tr>
<tr>
<td>b. Be sure this is addressed in your hospital policy.</td>
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<tr>
<td>4. Initiate banding upon admission, changes in condition, or when new information is received during the patient’s hospital stay.</td>
<td><strong>7. Educate staff to verify patient color-coded “alert” wristbands upon assessment, hand-off of care and facility transfer communication.</strong></td>
</tr>
<tr>
<td>5. Remember, the wristband is a tool to communicate an alert status, so make sure staff is educated to always utilize the patient’s medical record for verification of allergies, fall risk, advance directives, latex allergies, and restricted limb use.</td>
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Background

- In 2005, Pennsylvania had a “near miss” when confusion in wristband color resulted in patient being labeled DNR erroneously

- MHA Patient Safety Committee commissioned task force to evaluate statewide standards

- As of August 2007—11 states standardized wristband colors
In Pennsylvania, a patient was almost NOT resuscitated in a hospital because of confusion about the meaning of yellow wristbands.

A yellow wristband was placed on the patient by a nurse to indicate “restricted extremity”
- yellow meant “do not resuscitate” in that hospital
- yellow meant “restricted extremity” at the other hospital where the nurse worked

Following the incident, Pennsylvania developed a statewide guideline for the use of colored wristbands. A number of states have followed Pennsylvania’s lead.

In December 2005, a patient safety advisory was issued from the Pennsylvania Patient Safety Reporting System that received national attention.

This advisory brought to the surface an incident that occurred in a hospital in which clinicians nearly failed to rescue a patient who had a cardiopulmonary arrest because the patient had been incorrectly designated as “DNR” (Do Not Resuscitate).

The source of confusion was a nurse who had incorrectly placed a yellow wristband on the patient. In that hospital, a yellow wristband meant DNR. In a nearby hospital, where the nurse also worked, yellow meant “restricted extremity,” which was what she wanted to alert staff about. Fortunately, in this case, another nurse recognized the mistake and the patient was resuscitated.

Most of us can imagine this type of near miss occurring in any institution, and can clearly understand that the potential for confusion is fairly obvious, significant, and avoidable.
In October 2008, MHA’s Council on Clinical and Quality Issues and the Maryland Patient Safety Center were asked to evaluate the feasibility of hospitals and other healthcare organizations implementing a voluntary program to adopt a color coded patient alert wristband system, similar to that of 35 other states.

MHA’s Council on Clinical and Quality Issues, as well as the Maryland Patient Safety Center’s Patient Safety Officers Forum, supported adoption of the standardized wristband colors designating a defined set of patient safety risks based on the work of other states such as:

Pennsylvania standardized the use of colored wristbands for allergy, fall risk, do not resuscitate, latex allergy and restricted extremity. Their recommendation for allergy and fall risk is the same as that recommended in Missouri.

Arizona also standardized the use of colored wristbands after the Pennsylvania incident. The Arizona standards are the same as those recommended in Missouri.

California, Colorado, Nevada, New Mexico, and Utah have also adopted the same standards as recommended in Arizona. Several other states are in the process of standardizing the use of colored wristbands.

To date no national organization has taken on a project to standardize colored wristbands; however, private efforts are beginning to establish some commonality across the United States.
Workgroup was then established by Maryland Patient Safety Center

- Researched standardization of colored wristbands by Pennsylvania, Arizona and other states
- Confirmed no national organization was undertaking a similar project
- Reviewed sample materials from other states to determine which tools would provide the most information and assistance regarding implementation within each Maryland hospital
- Developed toolkit for distribution to all Maryland hospitals

Hospital logo

The Center’s team included nurses, hospital representatives, risk management consultants, quality improvement professionals, a researcher and vendor representation.
Risk exists in the non-standardized use of colored wristbands used to designate certain clinical conditions.

Communication is a contributing factor in most medical errors.

Standardization of wristband colors and messages improves communication about the patient’s clinical conditions.

Standardized use of colored wristbands between healthcare providers can improve patient safety.
Some may debate whether banding should occur at all. Literature review to-date has not conclusively identified a better intervention.

In today’s healthcare environment with many healthcare professionals working on different units and different facilities, and the use of agency and traveling staff, it is more difficult to remember where to find pertinent information quickly to assist in providing healthcare to patients.

Using standardized colored wristbands will help quickly alert caregivers across healthcare settings to high priority clinical conditions.

The recommendations were made with consideration given to human factor issues, industry standards, standardization that has occurred already in other states and common sense.
Text on the wristband is another way to communicate pertinent information.

It will also make sure information is communicated to individuals who may have color-blindness to one of the standardized colors used on the wristbands.

Many patients, young and old, are wearing social cause bracelets, such as the Lance Armstrong, Live Strong yellow bracelets; Pink Breast Cancer Awareness bracelets, etc. To avoid confusion, such wristbands should be removed or, at a minimum, covered up during the patient’s hospital stay to avoid any confusion. Likewise, wristbands that the patient may have had placed at another healthcare facility should be removed upon admission.

Wristbands are also a way to communicate pertinent clinical information to other healthcare settings where patients may be transferred; therefore, it is recommended the colored bands placed on patients during hospital stays remain on the patients until they return home or are transferred to another facility.
Red for Allergy Alert

It is recommended that hospitals adopt the color RED for ALLERGY ALERT with words “Allergy Alert” or “Allergy” printed on wristband.

By adopting RED for allergy alert, standardization is easily achieved since all of Maryland’s neighboring states use it to designate allergy to food, drug or latex.

Why was red selected?
Red was selected because all of Maryland’s neighboring states already use it to designate allergy to drug, food or latex. Therefore, it makes the most sense to continue with this established color that is already being used and is beginning to become a national standard to designate allergy.

Additionally, research of other industries reveals that red is associated with extreme concern. The American National Standards (ANSI) has designated certain colors with very specific warnings. ANSI uses red to communicate “Stop!” or “Danger!” and as such, this message should hold true for communicating an allergy status. When a caregiver sees a red allergy alert band, they are prompted to “Stop!” and double check to determine if the patient is allergic to medication, food, or any other treatment they are about to receive.

Does this mean we can no longer use Red or “R” on bands to designate blood bank information?
Red is also commonly used on blood bank wristbands and this recommendation does not intend to circumvent any current blood banking color system. It is anticipated that blood bank wristbands are very commonly known throughout the hospital and the red wristbands to be used for allergy will be easily distinguishable from the blood bank bands. The allergy bands are also recommended to include visible text stating “Allergy Risk” or “Allergy.”
FAQs

- Is there any national standard for the use of colored wristbands?
- Why was red selected for allergy alert?
- Do we write the actual allergy patient has on wristband too?
- Why is a separate standardized color to designate late allergy not part of recommendation?
- Does this mean red will no longer be used for blood bank banding?
Yellow for Fall Risk Alert

It is recommended that hospitals adopt the color YELLOW for Fall Risk Alert with the words “Fall Risk” printed on the wristband.

In Maryland, through FY 2008, Falls was the second most frequently reported incident.
In Maryland, through FY 2008, almost 25% of patients who fell in healthcare facilities sustained an injury.
In Maryland, deaths resulting from falls in healthcare facilities were the most frequently reported serious adverse event to the Office of Healthcare Quality.

Why was yellow selected for “fall risk”? 
Research showed that other industries associate yellow with “Caution!” such as traffic lights – to proceed with caution or stop altogether. The American National Standards Institute uses yellow to communicate “Tripping or Falling Hazards.” This fits well in healthcare as well when associated with a fall risk. Caregivers would want to be alert to and use caution with a person who has a history of falls, dizziness, balance problems, fatigability, or confusion about their current surroundings.

Yellow was also selected by our neighboring states, Pennsylvania, Virginia, New Jersey, West Virginia, as well as more than half of all the states in the country who have voluntarily adopted this program to designate fall risk. Based on these findings, it makes the most sense to continue with yellow, an established color that is already being used and is beginning to become a national standard to designate fall risk.

There are some stats we could include here if you think it would be helpful……
In Maryland, through FY 2008, Falls was the second most frequently reported incident.
In Maryland, through FY 2008, almost 25% of patients who fell in healthcare facilities sustained an injury.
In Maryland, deaths resulting from falls in healthcare facilities were the most frequently reported serious adverse event to the Office of Healthcare Quality.

More than a third of adults aged 65 years or older fall each year.
Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes.
Of those who fall, 20-30% suffer moderate to severe injuries that reduce mobility and independence and increase the risk of premature death.
The total cost of fall injuries for people age 65 or older in 1994 was $27.3 billion (in current dollars).
By 2020, the cost of fall injuries is expected to reach $43.8 billion (in current dollars).
Hospital admissions for hip fractures among people over age 65 have steadily increased from 230,000 admissions in 1988 to 338,000 admissions in 1999.
The number of hip fractures is expected to exceed 500,000 by the year 2040.
As the aging population enters the acute care environment, one must consider the risk that is present and do everything possible to communicate that to hospital staff.
FAQs

- Why is yellow used to designate fall risk?
- Why use an alert band for fall risk?
It is recommended that hospitals adopt the color PURPLE to designate Do Not Resuscitate and use the letters “DNR” printed on the wristband.

Calling CODE BLUE!
Most hospitals use Code Blue to call a code team to resuscitate a patient. If the color blue was selected for the DNR wristband, potential for confusion exists. “Does blue mean I code or I do NOT code?”

Why not use Blue to designate “DNR”? Based on the work that was initiated in Pennsylvania, “blue” was initially evaluated as a potential color to standardize “DNR.” However, Arizona and its surrounding five states, were using “purple” to standardize “DNR,” and this was reviewed and rationale behind their respective decisions considered. It is common for a “Code Blue” to be called in hospitals when a patient requires resuscitation. If a blue wristband designates “no code” and a “Code Blue” is called to resuscitate a patient, confusion could exist in whether the blue band means “to code” or “not to code.” To avoid creating any second guessing in this situation, the decision was made to adopt the same guideline as in the Southwestern states – Purple to designate “DNR.” Since our neighbors also use the color “purple” to designate a patient’s “DNR” status, Maryland is adopting it as well.

Why not green? Green appears to be used by a number of Maryland hospitals for DNR, which was considered when these recommendations were made. However, due to color blindness concerns it was decided to avoid using green. Also, in other industries, the color green often means “Go Ahead,” such as with traffic lights. Therefore, to avoid any possibility of communicating the wrong message, the decision was made not to recommend the use of green.
FAQs

- If we adopt the purple DNR wristband, do we still need to look in the chart?
- How will using purple to designate DNR in hospital setting coordinate with potential future designation for out of hospital DNR?
- My hospital doesn’t use wristbands for DNR. Why should we consider adopting this guideline?
- Why not use blue to designate DNR?
- Why not use green to designate DNR?

Hospital logo

Consider handing out the FAQ form and engaging the audience in reading the answer to these questions.
Pink for Restricted Extremity

It is recommended that hospitals adopt the color PINK for the restricted extremity alert designation with the words “RESTRICTED EXTREMITY” printed on the wristband.

Restricted Extremity

Most hospitals use Code Blue to call a code team to resuscitate a patient. If the color blue was selected for the DNR wristband, potential for confusion exists. “Does blue mean I code or I do NOT code?”

Which extremity should the restricted extremity band go on?

The restricted extremity band should be placed on the affected extremity. This alert wristband can also be placed on the extremity that should not be used for blood pressure measurement, IV insertion or other medical procedures secondary to certain medical conditions such as previous history of breast cancer or lymphedema.
It is recommended that hospitals adopt the color GREEN for the latex allergy alert designation with the words “LATEX ALLERGY” printed on the wristband.

**Why was green selected?**

Green was selected due to the color having a close association with the environment. Although many hospitals may not necessarily use a separate band for latex allergy, many facilities may use another form of designation to alert hospital staff, including a sticker on the chart or placard outside of the patient’s hospital room. The recommendation for standardization of color extends beyond wristbands to include any form of designation that is associated with a medical condition. The purposes of the recommendation for latex allergy is to provide a standard color (green) for healthcare providers, which can be easily identified and readily associated with allergies to latex.
FAQs

- How does this project coordinate with regional disaster planning groups that are implementing standardized triage banding of patients in the field using red, yellow and green?
- Who chose these colors?
Policy and Procedure

NOTE TO HOSPITAL:

- Use this slide to provide highlights of the policy and procedure changes or new policy and procedure used to implement this project at your hospital.
- Include information about when during hospitalization the wristbands are to be reviewed, removed, and/or replaced.
- Reinforce the importance of communication at admission with patients and families and during care handoffs with other clinicians.

Hospital logo
NOTE TO HOSPITAL:

- Use this slide to provide aspects of the work plan important for staff to know in order to implement the project.
Other Risk Reduction Strategies

- Initiate banding on admission for changes in conditions and when pertinent information is obtained during hospitalization
- Removal of non-hospital bands – social cause bands and bands placed in other healthcare settings
- Use the same color coding for other items such as the chart, whiteboard, care plan, door signage, stickers, etc.
- Educate patients and families about hospital’s banding policy
- Educate staff to verify colored wristbands on assessment, hand-off of care and facility-to-facility transfer communication
- If Broselow® coding systems are used, coordinate it with wristband colors

Hospital logo
NOTE TO HOSPITAL:

- Use this slide to provide aspects of the work plan important for staff to know in order to implement the project.

Hospital logo
NOTE TO HOSPITAL: Hand out the patient brochure and review it with the audience. Also hand out the staff brochure and review the script included in the brochure.

- Patient brochure
- Admission
  - Check for wristbands worn into the hospital, explain why they should be removed and remove them
  - Explain the use of bands and their meanings (use script provided in the staff brochure)
- Discharge
  - Provide instructions about bands to be removed if discharged home
  - Provide information about why bands are left on if transferred

The Staff Brochure contains a script to provide staff with consistent information and to reinforce the same information to patients and their families.
Community Involvement

NOTE TO HOSPITAL:
- Include information about organizations your hospital has contacted about the use of colored wristbands
- Discuss what other providers in the market area are implementing the project

Hospital logo

Reinforce the importance of communicating to community organizations about the hospital policy and removal of “social cause” wristbands worn into the hospital by patients.

Reinforce the importance of other healthcare providers, as appropriate, participating in the initiative to achieve a community-wide standard.
NOTE TO HOSPITAL:
- Discuss actual banding products that your hospital will use
- Include actual examples if possible

Be sure to address any other wristbands that are used at the hospital, including blood bank bands that are red.

Also discuss the use of Broselow tapes for pediatric patients to make sure there is no confusion with the colors used.
NOTE TO HOSPITAL:
Include information about hospital contacts for project

Vivian Miller, Research Project Manager
Maryland Patient Safety Center
410-379-6200, ext. 3508
vmiller@marylandpatientsafety.org

Beverly Miller, Senior Vice President
Maryland Hospital Association
410-379-6200, ext. 3332
bmiller@mhaonline.org
Add new slide: Click and Insert Headline

Click & Insert Headline- make bold
- Insert text at bullet

Click & Insert Headline- make bold
- Insert text at bullet
**Staff Competency**

**Purpose:** These are the standards of the technical competencies necessary for performance and/or clinical practice, relating to standardized wristband colors for patient safety.

To meet competency standards, the employee must demonstrate proficiency in performing the technical procedures safely as evidenced by department-specific criteria.

<table>
<thead>
<tr>
<th>Methods to Use:</th>
<th>A. Demonstration</th>
<th>B. Direct Observation/Checklist</th>
<th>C. Video/PowerPoint Review</th>
<th>D. Skills Lab</th>
<th>E. Self-Study Test</th>
<th>F. Data Management</th>
<th>G. Other</th>
</tr>
</thead>
</table>

Supervisor’s initials signify competency was met.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Job Title</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Color Code – what do the five (5) colors mean?</th>
<th>Date</th>
<th>Method Used (Indicate letter(s) A – E)</th>
<th>Supervisor’s Initials</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>When does the application of the wristband(s) occur?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy on patients not allowed to wear the “Social Cause” bands</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient education and how to communicate (script) the information with patients/families</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for Re-Application of Wristband</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication re: wristbands during transfers and other reports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient refusal to comply policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge instructions for home and/or facility transfer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Initials</th>
<th>Signature</th>
<th>Initials</th>
</tr>
</thead>
</table>

---

**Employee Signature**

**Maryland Hospital Association**

**Maryland Patient Safety Center**
Tab 6: Sample Resident/Patient Education Materials

Purpose: The enclosed sample brochure may be used and adapted as patient or resident materials about wristband colors and standardization.

Please feel free to add your hospital logo if you desire.
Our Hospital is proud to be a supporter of this collaborative work, making healthcare safer and better for patients and their families.

Maryland healthcare providers are working together with you to make Maryland’s healthcare the safest in the nation. We accomplish this goal by working on statewide projects in an endeavor to use the same methods or processes, like color-coded wristbands.

This helps improve communication among patients, families and healthcare providers.

(Insert hospital logo here)

Patient Safety:
Understanding what your color-coded “alert” wristbands mean
Ensuring clear communication is a key factor in providing a health care environment free of errors. Standardizing communication practices, similar to what is done in the aviation industry, is a very effective technique for improving the transfer of information about patient care. Maryland hospitals and providers are committed to offering safe care every time. We accomplish this in several ways, one of which includes using the same colors for “alert” wristbands.

Alert wristbands are used in hospitals to quickly communicate a certain health status or an “alert” that a patient may have. This is done so all staff members can provide the best care possible, even if they do not know the patient.

The different colors have certain meanings. The words for the alerts are also written on the wristband to reduce the chance of confusing the alert messages.

This initiative is not only throughout the state, but has also been adopted in over half of the states across the country, including all of the Mid-Atlantic states – Virginia, Delaware, Pennsylvania, New Jersey and West Virginia.

What do the different colors mean?

There are five different color-coded “alert” wristbands that we are going to discuss because they are the ones most commonly used.

**RED means ALLERGY ALERT**
If a patient has an allergy to anything, such as food, medicine, dust, grass, pet hair, or ANYTHING at all, please tell us. It may not seem important to you, but it could be very important in the patient care received.

**YELLOW means FALL RISK**
We want to prevent falls at all times. Nurses review patient information all the time to determine if a patient may need extra attention in order to prevent a fall. Sometimes, patients become weakened during their illness or because they just had surgery. When a patient has this color-coded wristband, the nurse is saying this person needs to be assisted when walking or they may fall.

**PURPLE means DNR or Do Not Resuscitate**
It is important we honor a patient’s wishes for end-of-life care.

**GREEN means LATEX ALLERGY**
Some patients are specifically allergic to latex and there are alternative products caregivers can use. We want to assure a safe environment for our patients, and it can be as simple as using latex free products.

**PINK means RESTRICTED LIMB**
Sometimes a patient’s arm shouldn’t be used for taking a blood pressure reading, drawing blood or inserting an IV. This band tells us to be sure we use the correct arm.

It is important that the patient and families know these colors and their meanings because you are the best source of information.

Keep us informed.
If there is information we do not know, such as a food allergy or a tendency to lose balance and almost fall, share that with us because we want to provide the best and safest healthcare to all of our patients.

Also, if you have an Advance Directive, tell us so. An Advance Directive tells your doctor what kind of care you would like if you become unable to make medical decisions. We want to respect and honor a patient’s wishes and that is done best when we have all of the information.
Tab 7: Sample Community Education

Purpose: The enclosed sample PowerPoint Presentation may be used and adapted as community education materials about wristband colors and standardization at your hospital/organization.
In December 2005, a near tragic incident was reported in Pennsylvania
- A patient was almost NOT resuscitated in a hospital because of confusion about meaning of yellow wristbands

Yellow wristband was placed on patient by nurse to indicate “restricted extremity”
- yellow meant “do not resuscitate” in that hospital
- yellow meant “restricted extremity” at the other hospital where the nurse worked

Following the incident, Pennsylvania developed a statewide guideline for the use of colored wristbands. A number of states have followed Pennsylvania’s lead.

Pennsylvania standardized the use of colored wristbands for allergy, fall risk, do not resuscitate, latex allergy and restricted extremity. Their recommendation for allergy and fall risk is the same as that recommended in Missouri.

Arizona also standardized the use of colored wristbands after the Pennsylvania incident. The Arizona standards are the same as those recommended in Missouri. California, Colorado, Nevada, New Mexico, and Utah are also adopting the same standards as recommended in Arizona. Several other states are in the process of standardizing the use of colored wristbands, including all of the Mid-Atlantic states surrounding Maryland – many using the same recommendations being made in Missouri.

To date no national organization has taken on this project to standardize colored wristbands; however, private efforts are beginning to establish some commonality across the United States, including the American Hospital Association and the American Society for Healthcare Risk Management, both of whom have endorsed the standardization of color-coded patient alert wristbands.
MHA/MPSC were asked to evaluate the feasibility of hospitals and other healthcare organizations implementing a voluntary program to adopt a color coded patient alert wristband system, similar to that of more than half of all the states nationwide.
Why Standardization is Important

- Use of wristbands alert hospital staff in all locations about patient conditions improves communication with and care provided to patients.
Why Standardization is Important

- Many healthcare professionals work in more than one healthcare setting
- Temporary and traveling staff are commonly used by hospitals to fulfill staffing needs
- Such staff are less familiar with how to quickly access clinical information
- Key clinical information must be communicated quickly during a crisis, evacuation and while a patient is transported between units and facilities
- Use of colored wristbands accomplishes this communication

Hospital logo
Wristbands left on patients when discharged from hospital communicate important conditions if patient is transferred to another healthcare setting.

Hospital logo
Recommendations for Implementation

- Limited number of high priority clinical conditions should be designated by standardized wristband colors
- Text should be used on wristbands
- Hospitals should serve as community leaders to educate the community and other providers about the project and engage their participation
- Wristbands worn into hospital should be removed on admission
- Wristbands placed in hospital should be left on at discharge to facilitate communication

Hospital logo
Some may debate whether banding should occur at all. Literature review to-date has not conclusively identified a better intervention.

In today’s healthcare environment with many healthcare professionals working on different units and different facilities, and because of the prevalent use of agency and traveling staff, it is more difficult to remember where to quickly find pertinent information to assist in providing healthcare to patients.

Using standardized colored wristbands will quickly help alert caregivers across healthcare settings to high priority clinical conditions.

These recommendations were made with consideration given to human factor issues, industry standards, standardization that has occurred already in many other states, and common sense.
Red for Allergy Alert

Recommendation:
hospitals adopt the color RED for ALLERGY ALERT with the words “Allergy Alert”/”Allergy” embossed/printed on the wristband

By adopting red for allergy alert, standardization is easily achieved since the majority of Missouri hospitals already use the color Red to designate Allergy

Why was red selected?
Red was selected because the Missouri hospital survey revealed a majority of hospitals were using red to designate allergy to drug, food or latex.

Red is also the color for allergies standardized in Pennsylvania, Arizona, the surrounding 5 southwest states, and all of the Mid-Atlantic states surrounding Maryland.

Other industries associate “red” with extreme concern. The American National Standards Institute uses red to communicate “Stop!” or “Danger!” This message should hold true for communicating an allergy status. When a caregiver sees a red allergy alert band, they are prompted to “Stop!” and double check to determine if the patient is allergic to the medication, food, or treatment they are about to receive.

Why is a separate standardized color to designate latex allergy not part of the recommendation?
To address the concern that too many standardized colors could increase confusion and staff would have difficulty remembering all of them, “red” is used to alert staff to the patient having an allergy, regardless of type. The band should prompt staff to confirm the allergy with the patient and/or check the medical record.
Yellow for Fall Risk Alert

Recommendation: hospitals adopt the color YELLOW for Fall Risk Alert with the words “Fall Risk” embossed/written on the wristband.

Falls account for more than 70 percent of the total injury related health cost among people 60 years of age and older.

Yellow commonly means “Caution” – “Proceed with caution!” like we do with patients that have a risk of falling.

Why did you select yellow?
Other industries associate yellow with “Caution!,” such as traffic lights – to proceed with caution, or to stop altogether. The American National Standards Institute uses yellow to communicate “Tripping or Falling Hazards.” This fits well in healthcare as well, when associated with a fall risk. Caregivers would want to be alert to and use caution with a person who has history of falls, dizziness, balance problems, fatigability, or confusion about their current surroundings. Yellow was also selected by Pennsylvania, Arizona, Missouri, and many other states to designate fall risk. Based on these findings, it makes the most sense to continue with yellow, which is an established color that is already being used, and is beginning to become a national standard to designate fall risk.
Purple for DNR

Recommendation:
hospitals adopt the color
PURPLE to designate
Do Not Resuscitate
and use the letters “DNR”
embossed/printed
on wristband.

Why not use Blue to designate “DNR”?
The work in Pennsylvania, where “blue” is used to standardize “DNR,” Arizona and
its surrounding five states, as well as many other states where “purple” is used to
standardize “DNR,” was reviewed and the rationale behind their respective
decisions considered. It is common for a “Code Blue” to be called in hospitals
when a patient requires resuscitation. If a blue wristband designates “no code” and
a “Code Blue” is called to resuscitate a patient, confusion could exist in whether the
blue band means “to code” or “not to code.” To avoid creating any second guessing
in this situation, the decision was made to adopt the same guideline as in the
Southwestern states – Purple to designate “DNR.”

Why not green?
Green appears to have been used by a number of hospitals in Missouri for DNR,
which was considered when these recommendations were made. However, due to
color blindness concerns, it was decided to avoid using green. Also, in other
industries, the color green often means “Go Ahead,” such as with traffic lights.
Therefore, to avoid any possibility of communicating the wrong message, he
decision was made not to recommend the use of green.
Pink for Restricted Extremity

It is recommended that hospitals adopt the color PINK for the restricted extremity alert designation with the words “RESTRICTED EXTREMITY” printed on the wristband.

Which extremity should the restricted extremity band go on?
The restricted extremity band should be placed on the affected extremity. This alert wristband can also be placed on the extremity that should not be used for blood pressure measurement, IV insertion, or other medical procedures secondary to certain medical conditions such as previous history of breast cancer or lymphedema.
It is recommended that hospitals adopt the color GREEN for the latex allergy alert designation with the words “LATEX ALLERGY” printed on the wristband.

**Why was green selected?**

Green was selected due to the color having a close association with the environment. Although many hospitals may not necessarily use a separate band for latex allergy, many facilities may use another form of designation to alert hospital staff, including a sticker on the chart or placard outside of the patient’s hospital room. The recommendation for standardization of color extends beyond wristbands to include any form of designation that is associated with a medical condition. The purposes of the recommendation for latex allergy is to provide a standard color (green) for healthcare providers, which can be easily identified and readily associated with allergies to latex.
Hospital staff will educate patients upon admission about this policy

- Patient brochure explain use of colored wristbands
- Request removal of social cause wristbands on admission
- Instructions about wristbands upon discharge
Community Involvement

- Social cause wristbands on patients when in the hospital may increase confusion
- Patients asked to remove or cover bands at admission
- To improve patient safety in the community and statewide, healthcare providers are asked to standardize use of colored wristbands

Hospital logo

NOTE TO HOSPITAL: All Maryland hospitals have implemented nationally recommended disaster preparedness procedures and policies that recommend the use of colored wristbands for triage and tracking from the field (for ambulance transportation), so you may also want to mention this. The Banding Together project only addresses banding within hospitals, and includes the recommendation that all bands that have been placed on patients prior to arrival at a health care facility, be removed at admission. Therefore, there should not be any conflict between the Banding Together recommendations and these disaster planning activities.
NOTE TO HOSPITAL:
- You may want to provide examples of hospital bands to increase community awareness
Tab 8: Sample Poster

Purpose: The sample poster provides a visual cue about the Maryland standard wristband colors. The poster audience is for patients, but it could also be adapted to be used for staff education and to include other relevant facility information.

Please feel free to add your hospital logo if you desire.
“Name of Hospital” is committed every day to providing safe patient care. This means that if you suffer from an allergy, are at risk for falling, have chosen not to be resuscitated, have a latex allergy or have restricted limb use, you will be asked to wear a wristband as an alert to those caring for you.

If you have any questions about this safety practice, please ask your nurse or call____________________.
Tab 9: Sample Healthcare Provider Letter

Purpose: This sample letter provides information to your Medical Staff/Allied Health Care Professionals about your hospital’s voluntary implementation of Maryland’s “Get on the Bandwagon for Patient Safety” Wristband initiative. It also alerts health care professionals of the significance of each colored wristband, and to be advised of the need to clarify the intent of a band before treating a patient.

Please feel free to add your hospital logo to the letter if your desire.
"Get on the Band Wagon for Patient Safety"

Healthcare Provider Sample Letter  {Insert Hospital Logo}

This letter is to alert you to a patient safety issue involving the use of colored wristbands in healthcare settings and an initiative our hospital is undertaking to decrease risks to patients from the use of such bands.

In December 2005, the Pennsylvania Patient Safety Authority was made aware of a near-miss, potential tragedy at a Pennsylvania hospital related to misinterpretation of colored wristbands. Such bands were routinely used by hospital staff to convey important clinical information; however, there are no standardized regulations for where or when to use the wristbands or what colors of wristbands to use. In addition to Pennsylvania, 35 other states nationwide have subsequently established voluntary guidelines standardizing the use of a number of colors for wristbands to designate common clinical conditions.

Following this lead, Maryland Hospitals, with endorsement from the Maryland Hospital Association and the Maryland Patient Safety Center, have voluntarily adopted the use of the following standardized colors:

<table>
<thead>
<tr>
<th>Band Color</th>
<th>Communicates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Allergy</td>
</tr>
<tr>
<td>Yellow</td>
<td>Fall Risk</td>
</tr>
<tr>
<td>Green</td>
<td>Latex Allergy</td>
</tr>
<tr>
<td>Purple</td>
<td>DNR Status</td>
</tr>
<tr>
<td>Pink</td>
<td>Restricted Limb Use</td>
</tr>
</tbody>
</table>

{Enter your hospital name here} has joined this initiative to reduce risks to patients from misinterpretation of colored wristbands and improve communication between caregivers, patients and families by implementing this standardization which designates the above clinical conditions.

As a healthcare provider, you will likely treat and/or transport patients that will be wearing colored wristbands; therefore, we want to alert you to the significance of each color. If you receive patients from {Enter your hospital name here} you will soon be seeing these wristbands on patients if they have an allergy, fall risk, latex allergy, a DNR order or restricted use of a limb. Our hospital policy is to leave these wristbands on patients upon discharge to facilitate communication between healthcare providers and to remove wristbands worn by patients when admitted to the hospital to avoid confusion.

However, also be aware, there may be organizations that are not adopting these standardized colors; therefore, you will always need to clarify the intent of the band before treating a patient.
We ask, at a minimum, that you alert your staff to this standardization of wristbands occurring across the state. In addition, if appropriate, we ask you to consider implementing the same standardization of colored wristbands at your facility to help establish a true community-wide standard to improve patient safety.

Resources for implementation of the initiative are available from the Maryland Patient Safety Center at www.marylandpatientsafety.org, or by contacting the Center at 410-379-6200.

Thank you for your consideration. If you wish to discuss this initiative further, please contact Vivian Miller at 410-379-6200, extension 3508.
Tab 10: Sample Banding Products

Purpose: Neither the Maryland Hospital Association nor the Maryland Patient Safety Center support any specific vendors, but do wish to provide examples of information and systems offering wristband products that facilities may wish to consider.

This tab includes a Banding Products Advisory and an example of a set of products from the vendors included in this section.
Banding Products

Banding Products Advisory

Throughout the process of developing this project, information was obtained from vendors that currently provide wristbands to Maryland hospitals.

Most providers belong to a Group Purchasing Organization that works with your Materials Management Department. These vendors have various banding options that meet the recommendation of the Maryland “Get on the Bandwagon for Patient Safety” Wristband initiative.

This toolkit contains information about options available from two vendors, Precision Dynamics® and St. John Companies™. Contact information is also provided for representatives from each company who are available to discuss options with you. The Maryland Patient Safety Center and the Maryland Hospital Association do not endorse any one vendor.

Any decision about procuring banding products is an individual decision to be made by each participating health system and/or hospital. The information in this toolkit is provided for informational purposes only.

Examples of the products and additional information from each of the above companies are available in the enclosed white envelope.

It is also important, when making a decision about banding products, to consider any implications for the use of bar codes, photos, and the use of bands for varying patient populations, such as Broselow® tape in the pediatric population.

In an effort to obtain as much standardization as possible in the color and text used on the wristbands, and to match from facility to facility, the vendor of choice will need the following information:

<table>
<thead>
<tr>
<th>Allergy Type</th>
<th>Color</th>
<th>Text</th>
<th>Font</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>Red – PMS 1788</td>
<td>“ALLERGY” in Black</td>
<td>Arial Bold, 48 pt., all caps</td>
</tr>
<tr>
<td>Fall Risk</td>
<td>Yellow – PMS 102</td>
<td>“FALL RISK” in Black</td>
<td>Arial Bold 48 pt., all caps</td>
</tr>
<tr>
<td>DNR</td>
<td>Purple – PMS 254</td>
<td>“DNR” in White</td>
<td>Arial Bold, 48 pt., all caps</td>
</tr>
<tr>
<td>Latex Allergy</td>
<td>Green – PMS 1905c</td>
<td>“LATEX ALLERGY” in Black</td>
<td>Arial Bold, 28 pt., all caps</td>
</tr>
<tr>
<td>Restricted Extremity</td>
<td>Pink – PMS 1905c</td>
<td>“RESTRICTED EXTREMITY” in Black</td>
<td>Arial Bold, 28 pt., all caps</td>
</tr>
<tr>
<td>Wristband Products</td>
<td>Admitting</td>
<td>Alert</td>
<td>Blood</td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td></td>
<td>The St. John Companies provides positive patient identification solutions for healthcare facilities. Whether your facility imprints, applies a label, or adds a barcodes to your wristbands, the St. John Companies offers the right solution for you. With the largest selection of patient identification solutions available, the St. John Companies is the right choice.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Next Steps**
- **FREE Samples**
- **Contact Me**
- **FREE Brochures**
- **Check Printer Compatibility**

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**News & Announcements**
- 4/30/09 HealthTrust Awards two Contracts to The St. John Companies
- 2/13/09 GSA Awards Contract to The St. John Companies

More news . . .

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http://www.patientidexpert.com/index_stjohn.html
Alert Band® Wristbands & Snaps

The healthcare community has recognized the urgent need for standardized color code indicators to identify special risk patients. Reports from staff members using color code indicators demonstrate a high satisfaction rate, providing a positive impact on patient safety.

PDC's Color Coded Alert Bands® and Ident-Alert™ Snaps feature highly visible, color-specific identification alerts to warn caregivers of special precautions. They are a quick, easy and cost-effective way to meet state standardization. Features include extra large type, bright colors, and patented SecurSnap® closure for maximum safety and security.

PDC's Alert Band® meets guidelines of the pioneering Arizona and Pennsylvania "Safe and Sound" and "Color of Safety" color coding initiatives.

- Extra large text provides clarification to clinicians (assisting in dim light conditions or for those who are color blind).
- Only primary and secondary colors used as indicators. Patented SecurSnap® closure prevents transfer of wristbands.
- Provide maximum security and comfort. Custom logos & cues communicate less common conditions.
- All wristbands are latex-free.

Alert Bands® Meet these Joint Commission Patient Safety Goals:

Goal #1: Improve the accuracy of patient identification
Goal #2: Improve the effectiveness of communication among caregivers
Goal #9: Reduce the risk of patient harm resulting from falls
Goal #13: Encourage patients' active involvement in their own care as a patient safety strategy

SEE STATE information on color coding standardization initiatives.
Measures may be coming to your city and/or state in the future!

**Sentry® SuperBand® Alert Bands® 5055**

- Lightweight non-stretch polyester
- Patented SecurSnap® closure
- Extra large text provides clarification to clinicians
- 500 per box
- Price: Call To Order

**Sentry® SuperBand® Alert Bands® 5075**

- Lightweight non-stretch polyester
- Patented SecurSnap® closure
- Extra large text provides clarification to clinicians
- 500 per box
- Price: Call To Order

**Clearimage® Alert Bands® 130A**


8/20/2009
Lightweight non-stretch polyester
Patented SecurSnap® closure
Extra large text provides clarification to clinicians
500 per box
Price: Call To Order

Sentry® SuperBand® Alert Bands® 5052

Lightweight non-stretch polyester
Patented SecurSnap® closure
Pre-printed Allergy Alert logo
250 per box
Price: Call To Order

Short Stay Tabless™ Alert Bands®

Adhesive closure | Tyvek® material
Unique patented single piece tabless design
Imprinted with Alert Status

Price: Call To Order

Safeguard® Alert Bands® 824A

Constructed of secure tri-laminate material | Adhesive closure
Pre-printed Allergy Alert logo
Surface can be used with imprinter or write-on with pen
250 per box
Price: Call To Order

Ident-Alert™ Colored Snaps

Alternative Alert tool for use with any PDC snap closure wristl
6 colors available | 100 per pack
Price: Call To Order

Other Alert Logos

Custom alert logos can be printed on PDC wristbands.
Price: Call To Order
Tab 11: Facility Implementation Report

Purpose: We hope you will join this initiative. In an effort to track the uptake of the “Get on the Bandwagon for Patient Safety” Wristband initiative, we request that you provide an update on your implementation status every six (6) months.

Please use the attached form to keep us informed of your progress.
Implementation Report

Participants in this project will be asked to provide the following information at six months and 12 months following implementation to track the progress and impact of this project throughout the state.

The Maryland Hospital Association and/or the Maryland Patient Safety Center will send the form and instructions to the project contact at each participating hospital.

Hospital Name ________________________________
Address _________________________________________
Contact Person ________________________________
Phone __________________ Fax _____________________
Email __________________________________________
Implementation of project Month __________ Year __________

If the project has NOT been implemented, provide a brief description of the barriers to implementation:

________________________________________________________________________

Hospital-based locations where standardized wristbands have been implemented:

(Check all that are applicable)
____ Nursing home
____ Home health
____ Ambulatory surgery center
____ Physician offices
____ Urgent care center
____ Other ____________________________________________
____ Other ____________________________________________
____ Other ____________________________________________

The following organizations have been contacted and encouraged to implement the voluntary guidelines for the use of colored wristbands:

Charitable Organizations Other Health Care Providers

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

FAX completed form to:
Vivian Miller, 410-379-9558
Tab 12: Acknowledgements

The contents of this Standardization and Implementation Toolkit are available from the Maryland Patient Safety Center, downloadable at the Center’s Website at www.marylandpatientsafety.org.

The Center can also be contacted at 6820 Deerpath Road, Elkridge, MD 21075-6324, phone 410-540-9210, fax 410-540-9139 or by e-mail to Vivian Miller, Risk Management/Patient Safety Specialist at vmiller@mhaonline.org.

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The “Get on the Bandwagon for Patient Safety” Work Group Team Members who provided input to MHA and MPSC, and served as reviewers of the toolkit.
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