Color-coded Patient Alert Wristband Standardization

Implementation Toolkit

September 2009
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Executive Summary

Improving patient safety, including reducing risks of injury or harm, has been a strategic focus of Tennessee Hospital Association (THA) through its Tennessee Center for Patient Safety.

THA is asking hospitals to improve communication consistency and reduce the risk of patient harm by standardizing color-coded patient alert wristbands.

In December 2005, the Pennsylvania Patient Safety Reporting System issued a Patient Safety Advisory that received national attention. This advisory highlighted an incident that occurred in a hospital in which clinicians nearly failed to rescue a patient experiencing a cardiopulmonary arrest because the patient had been incorrectly designated as do-not-resuscitate (DNR).

The source of confusion was a nurse who mistakenly 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” (meaning this arm is not to be used for drawing blood or obtaining intravenous (IV) access), which was her intended alert. Fortunately, another nurse recognized the mistake, and the patient was resuscitated.

This type of “near miss” could occur in Tennessee facilities. Based on a survey sent to THA member hospitals in December 2008, Tennessee hospitals use a variety of colors to indicate allergy, fall risk and DNR. Based on survey results, five different colors were being used to indicate allergy, seven different colors to indicate fall risk and seven colors to identify patients with DNR orders.

<table>
<thead>
<tr>
<th>Color</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Blue</td>
<td>38%</td>
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<tr>
<td>Other Colors</td>
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<tr>
<td>Purple</td>
<td>17%</td>
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<tr>
<td>Red</td>
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<td>Yellow</td>
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<td>Green</td>
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<td>Pink</td>
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As of summer 2009, nearly 30 states have standardized color-coded patient alert wristbands. Consistent with these states, THA is implementing a color-coded patient alert wristband standardization initiative focused on the three most commonly used patient alert wristband colors: red to indicate allergy, yellow to indicate fall risk and purple to indicate DNR. The purpose of the initiative is to consistently and effectively communicate an alert to a healthcare provider if the patient has an allergy, is a fall risk and/or carries a DNR order. With a standardized method of communicating these risks, the potential for confusion when patients, physicians and nurses travel between different hospitals is greatly reduced.

THA’s goal is to gain a 100 percent participation rate from Tennessee hospitals by December 31, 2009, ensuring the consistency of these three alerts. In addition, THA is collaborating with surrounding state hospital associations to ensure communication consistency and awareness among the states that border Tennessee.

While THA encourages standardization of these three patient alert wristband colors to ensure clear and consistent messaging throughout its membership, it is important to note this initiative does not require those hospitals that presently do not use color-coded patient alert wristbands to adopt the practice.

Use Agreement and Acknowledgements

This toolkit was adapted with permission from the Michigan Health and Hospital Association. Content was derived with permission from original works copyrighted by the Hospital & Healthsystem Association of Pennsylvania (HAP), Texas Hospital Association (THA) and Arizona Hospital and Healthcare Association (AzHHA). Individual hospitals may produce copies of this toolkit, as well as specific items in it, for their use in educating hospital staff members about the program. However, the three standard colors — purple for DNR, red for allergies and yellow for fall risk — may not be changed.
Background

Healthcare professionals are increasingly being employed simultaneously in multiple hospitals and other healthcare settings, and many facilities supplement local healthcare professionals with registry and traveling staff members. In addition, patients are being transferred between facilities during care. It is imperative that operational processes within hospitals/health systems take these combined factors into consideration when developing patient alert communication plans in individual facilities.

These patient safety and quality concerns led the Tennessee Hospital Association (THA) to examine the use of color-coded patient alert wristbands in Tennessee hospitals. The use of color-coded patient alert wristbands is not a substitute for medical record review, but serves as a reminder to caregivers to review a patient’s medical record prior to making critical care choices. Based on the need to provide caregivers across Tennessee with a consistent patient alert message delivery system, THA has determined the following:

- Hospitals/health systems that do not currently use color-coded patient alert wristbands should not start to do so.
- Hospitals/health systems that currently use color-coded patient alert wristbands, and wish to continue doing so, are advised to adopt the following three standards: red for allergy, yellow for fall risk and purple for do-not-resuscitate (DNR).
- Hospitals/health systems that use other color-coded visual cues, such as stickers or labels to communicate patient risk factors, should ensure these cues’ colors and language correspond with the standardized alert wristbands when appropriate.

<table>
<thead>
<tr>
<th>Wristband Color</th>
<th>Communicates</th>
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<tbody>
<tr>
<td>Red</td>
<td>ALLERGY</td>
</tr>
<tr>
<td>Yellow</td>
<td>FALL RISK</td>
</tr>
<tr>
<td>Purple</td>
<td>DNR</td>
</tr>
</tbody>
</table>
The Impact of Adoption

It is anticipated that adoption of standardized colors for wristbands statewide will result in improved quality of health care by reducing the risk that patients will receive incorrect care due to caregivers’ misunderstanding of the meanings of color-coded alert wristbands used to communicate clinical information.

The cost impact to healthcare facilities should be negligible. Facilities may incur incremental costs associated with embossing or preprinting information on color-coded alert wristbands if they do not already do so.

There will be an operational impact on facilities whose policies regarding wristband use are significantly different from this guidance. Transitioning to a new set of colors/meanings may itself potentially increase risk of error in the short term; however, this risk can be minimized through staff education and reinforcement during the transition period.

There is no set timeframe by which facilities using color-coded wristbands must adopt the standardized colors and meanings. This allows facilities to use up existing stock and schedule a transition at a time that minimizes confusion for staff. However, THA is striving to have every Tennessee hospital that currently uses alert wristbands to standardize by Dec. 31, 2009.

To assist in implementation, THA has created this toolkit, which includes resources developed in other states that have adopted standardized colors for wristbands.
Summary

Tennessee hospitals, as well as other healthcare facilities, are encouraged to voluntarily adopt standardized colors of wristbands or other visual cues, such as stickers or labels, by Dec. 31, 2009. A clearly defined and consistently implemented practice for identifying and communicating patient risk factors or special needs will support safe patient care.

Tennessee facilities implementing standardization of wristbands at their facility should develop policies and protocols that address the application of wristbands, patient and/or family education, staff education, and handoff communication for transfers within the facility or to another healthcare setting.
Important Reminders

There is no evidence that using color-coded patient alert wristbands is superior to traditional methods of communicating clinical information. Therefore, if healthcare facilities are not using this practice to communicate important clinical information, it is not suggested that they begin this practice. **Color-coded patient alert wristbands should only serve as a visual cue and alert to caregivers. It should not replace verification of information in patients’ medical records.**

- Do not rely on color alone to communicate the meaning of an alert. Wristbands serve as a visual cue, and caregivers always should review the medical chart to confirm patients’ clinical conditions or risks.
- When a discrepancy arises between a medical record and color-coded patient alert wristband, caregivers need to reconcile those differences by referring to the patient’s medical record as the source of truth.
- Educate staff to always utilize patients’ medical records for verification of allergies, fall risks and advance directives.
- Verify color-coded alert wristbands at the time of patient assessments, during patient care handoffs, during changes of shifts, when transfers occur between units, and at the time of discharge.

**Limit the use of color-coded wristbands to high alert medical conditions.**

- It is not necessary that a facility implement all three of these patient alert wristbands when adopting standardized wristbands. However, facilities should limit the total number of color-coded alert wristbands used in their institutions, excluding the patient identification band.
- If a facility chooses to implement color-coded patient alert wristbands for a clinical message, other than the three outlined in this toolkit, the facility should choose a color other than those used to indicate allergy (red), fall risk (yellow) and do-not-resuscitate (purple). Use primary and secondary colors. Avoid using shades of the same color for more than one wristband alert.
- Special consideration for the pediatric population has been identified. Facilities using the Broselow color-coding system for pediatric resuscitation charts should take steps to reduce the potential for confusion between the Broselow bands and the color-coded wristbands used to designate allergy, fall risk and do-not-resuscitate.
- Consider the potential for confusion between color-coded wristbands indicating a clinical condition or risk factor if your facility uses a colored wristband for patient identification information.
Use patient alert wristbands that are preprinted with text that clearly identifies the alert.

- This can reinforce the color-coding system for new clinicians, help caregivers interpret the meaning of the wristband in dim light, and help those who may be color blind.
- This step helps to eliminate the chance of confusing wristband colors with overhead alert messages.
- Some facilities have expressed reluctance to include preprinted text on the alert wristbands for fear of compromising patients' right to privacy. While it is important to respect every patient's right to privacy, The Joint Commission does not view the use of color-coded wristbands to be a violation of privacy in the healthcare setting.

Make sure alert wristbands reflect the current medical conditions of patients.

- Assign clinical staff members responsibility for checking, applying and removing color-coded wristbands.
- Upon admission to a hospital and during initial assessment of patients, apply patient alert wristbands appropriate to individual conditions and risk factors.
- Place appropriate wristbands on patients at the time of admission, when medical condition(s) change, or when additional information is updated or received during the course of the hospital stay.
- Document patients' conditions or risk factors in medical records.
- Develop a consistent protocol for anatomical placement of color-coded wristbands.
- Reassessment of the appropriateness of the color-coded wristband should be ongoing and scheduled at intervals during the patients’ care, including before invasive procedures, at transfer and during changes in level of care.
- If alert wristbands need to be removed during the course of treatment, apply new wristbands on another extremity prior to removing the wristbands that already are in place.
- Errors and/or omissions of alert wristbands should be corrected immediately when identified by a healthcare worker.

Remove wristbands that have been applied from another facility.

- Ensure that hospital policy and procedure is amended.
- Wristband standardization and implementation is voluntary in Tennessee, and as healthcare facilities elect to voluntarily implement this practice, the exact timing of implementation may differ among facilities. Therefore, existing wristbands should be removed at the time of admission to your healthcare facility.
Remove any “social cause” (such as LIVESTRONG, Alzheimer’s Disease) or other non-facility colored wristbands.

- Ensure that hospital policies and procedures are amended.
- Non-facility (or “community”) colored wristbands should not be worn in the healthcare setting and should be removed upon admission to a healthcare facility to avoid confusion with the facility’s color-coded patient alert wristbands.
- Explain the hazards to patients who refuse to remove non-facility wristbands once they are in the healthcare setting.
- If a patient refuses to remove the non-facility wristband, explain that the healthcare facility has attached meaning to certain colored wristbands, explain the potential risks to the patient, and request that the patient sign a refusal form. A sample form is included in the “Implementation Information and Resources” section of this toolkit.

Educate patients and their families regarding the purpose and meaning of the color-coded patient alert wristbands.

- As with most patient safety and quality initiatives, it is important to explain to patients and/or their families the purpose of color-coded alert wristbands and reinforce the importance of their involvement in their care.
- Remind patients and/or their families that the alert wristbands provide an important visual cue to caregivers about patients’ medical choices or conditions and provide an opportunity to prevent error.
- Advise patients and/or their families to contact a nurse or other healthcare provider if the wristband falls off or is removed and not reapplied immediately.
- Use the patient and family education brochure provided in this toolkit or another that has been developed by your own organization.

Educate healthcare workers on the purpose and meaning of the color-coded patient alert wristbands.

- Educate new employees about alert wristband use and meanings during orientation and reinforce with annual staff competencies.
- Develop a strategy and implementation plan to educate existing staff in the organization.
- Education components should include the risks of alert wristband usage, meaning of colors, staff responsibilities, reapplication of wristbands, communication during transfers within the facility, and discharge/transfer to another facility.
Leave the color-coded alert wristbands in place at the time of patient discharge.

- Color-coded wristbands should not be removed at discharge.
- For home discharges, the patient is advised to remove the wristband when he/she is off facility grounds.
- For discharges or transfer to another facility, the wristbands are left intact as a safety alert for staff at the next facility.
- The receiving facility is responsible for reassessment and subsequent wristband removal, reconfirmation and application.

**Human Factor Considerations**

Improving patient safety and quality is a critical goal for every organization, and a part of that goal is to reduce risks for injury or harm whenever possible. By implementing risk reduction strategies, organizations demonstrate a commitment to patient safety in a consistent fashion.

Risks are events that, when triggered, may potentially cause harm, significant injury or, in the worst case scenario, the death of a patient. The commitment to patient safety begins at the bedside and is underscored through leadership support to be proactive in the effort to ensure safe practice.

The initial step in maximizing patient safety is risk identification. Trends in adverse events or “the risk thereof” is key to organizational claim management. Failure to rescue, medication errors and falls consistently challenge organizations to improve patient safety and reduce financial losses. Medication errors and falls are among the highest reported incidents and often are underestimated “based on their everyday occurrence.” Human factors often are the root cause of such preventable events and related to a complicated communication process, an ever changing environment and a varying rotation of caregivers.

Communication is a key contributing factor of sentinel events that occur in the healthcare setting. One method to assist with effective communication is using color coding for alert wristbands. This provides a simplified tool that, when standardized, provides a continuous communication link within an organization, as well as among healthcare facilities.

Within the healthcare setting, the science of human factors addresses human performance within medical systems, particularly as it relates to processes of care, error management and patient safety. Error management involves not only decreasing errors themselves, but also decreasing the opportunity for error-causing situations to arise by designing safe systems that take human
To fully integrate human factors into wristband design, there are several key points to emphasize:

- Human error most frequently arises from stressful, busy, uncommon situations. Because of the dynamic nature of health care, it is important to structure our systems in a way that helps staff successfully complete their work. By standardizing alert wristbands across Tennessee, staff members no longer have to remember symbols or colors specific to a hospital; they are able to learn a single set of rules that apply at every hospital.
- The text printed on the alert wristband should not wrap around the entire wrist. This decreases the chance that risk information will be missed because it is on the other side of the wristband and was not seen.
- The minimal amount of information that is required should be displayed on the wristband. Key data should be placed where it can be seen first.
- Alert wristbands should be designed so that they highlight specific, pertinent information. Too much information can be difficult to distinguish and can be misread or misinterpreted, especially when caregivers are hurried. Visual cues, such as highlighting, can be used to make the information 'pop out;' however, the cue should be consistently used. The style and placement of information also should remain consistent for every wristband. Again, only the absolute minimal amount of information should be placed on the wristband. Limit abbreviations.
- When using text on the wristband, be sure to use large letters that are NOT italicized. Italics are more difficult for the eyes to quickly read and interpret.
- The alert text should always be in a color that contrasts with the color of the wristband. For example: blue print on a black background or vice versa is difficult to read, but black print on a yellow background is very easy to read.
- Reading ability improves with an increase in text size, but only up to a critical point at which it levels off. That critical point is dependent on the task; therefore, it would be beneficial to observe the task and determine how readable the text on the wristbands needs to be to allow for optimal performance.

In closing, taking human factors — human capabilities and limitations — into account will allow for a safer and more intuitive system. As a rule of thumb, simpler is always better. This advice is based on a broad spectrum of possible wristband designs, highly dependent on the amount and length of text. It is based on scientific research into human abilities to see, read, and perceive and interpret
information. Some of these considerations were taken into account in developing the vendor wristband specifications found later in this toolkit.

**Human Factors Resources**

Frequently Asked Questions

Improving patient safety, including reducing risks of injury or harm, is a strategic focus of the Tennessee Hospital Association (THA) through its Tennessee Center for Patient Safety (TCPS). The Tennessee Center for Patient Safety was recently designated as a patient safety organization (PSO). The Tennessee Center for Patient Safety is engaging hospitals in an effort to improve communication and reduce the risk of patient harm through the voluntary standardization of color-coded patient alert wristbands.

Similar initiatives are under way in more than 25 states in an effort to improve patient safety. This endeavor is not meant to encourage those hospitals that presently do not use color-coded patient alert wristbands to adopt the practice. Rather, the goal is to gain a 100 percent standardization rate among those Tennessee hospitals that currently use color-coded patient alert wristbands, ensuring the consistency of three alerts: allergy (red), fall risk (yellow) and do-not-resuscitate (purple).

Questions & Answers

Q: The hospital has never used color-coded patient alert wristbands. Should we start?
A: No. THA does not encourage hospitals to start using color-coded patient alert wristbands if they do not already use them. The standardization initiative is directed only to those hospitals/health systems that currently use color-coded patient alert wristbands in order to reduce preventable medical errors caused by lack of consistency in alert messages provided to caregivers.

Q: Why is THA leading an initiative to standardize color-coded patient alert wristbands?
A: The purpose of the initiative is to consistently and effectively communicate an alert to a healthcare provider if the patient has an allergy, is a fall risk and/or carries a do-not-resuscitate (DNR) order. With a standardized method of communicating these risks, the potential for confusion when patients, physicians and nurses travel between different hospitals is greatly reduced.

Q: How long will it take to standardize color-coded patient alert wristbands?
A: The process is unique for each hospital and can take several months. Our target for Tennessee is for facilities to complete this standardization by Dec. 31, 2009.

Q: What colors were chosen for standardization?
A: As of summer 2009, nearly 30 states have standardized color-coded patient alert wristbands. Consistent with these states and the American Hospital Association, the Tennessee Center for Patient Safety is implementing a color-coded patient alert wristband standardization initiative focused on the three most commonly used patient alert wristband colors: red to indicate allergy, yellow to indicate fall risk and purple to indicate do-not-resuscitate (DNR).

Q: What is the first step in pursuing standardization?
A: Members will be provided educational tools for conducting this standardization. These toolkits contain numerous sample communications and materials that inform hospitals about how best to carry out the standardization. This toolkit will be available online and the TCPS staff will be available throughout the process to answer questions.

Q: Do color-coded patient alert wristbands infringe on patient privacy and/or violate the Health Insurance Portability and Accountability Act (HIPAA)?
A: The use of color-coded patient alert wristbands does not violate HIPAA. Incidental release of patient information is allowed when necessary for hospital operations. The use of the color-coded patient alert wristbands falls under this allowed limited release of patient information.

Q: Why was purple selected for do-not-resuscitate (DNR)?
A: As other states considered the adoption of the standardized colors, there was a concern that using the color blue may cause confusion when responding to a code. Based on a survey of Tennessee hospitals, many hospitals call a “code blue” for cardiac arrest. Having a blue DNR wristband to indicate “no code” could easily cause confusion. To avoid creating any second guessing about whether to call a code in this critical moment, blue was not used.

Furthermore, the color green was avoided due to color blindness concerns. The color green also often has a “go ahead” connotation, such as with traffic lights. The possibility of sending mixed messages in a critical moment must be avoided.

Due to these reasons and to achieve consistency with the majority of states standardizing patient alert wristbands, Tennessee selected purple for DNR alert designation.
Q: If the hospital adopts the purple do-not-resuscitate (DNR) wristband, do staff members still need to look in the chart?
A: Yes. Some hospitals do not use wristbands to alert clinicians of an advance directive because they want the clinicians to review the medical record for the patient’s most current code designation. A medical record should always be reviewed for the patient’s most current code designation. Code status can change throughout a hospitalization, and it is important to know the current status, so the patients’ and/or families’ wishes can be honored.

Q: Why was red selected for allergies?
A: Research of other industries indicates that red has an association that implies extreme concern. The American National Standards Institute (ANSI) has designated certain colors as signifying very specific warnings. ANSI uses red to communicate “stop!” or “danger!” It is believed this message also would translate when communicating an allergy status. When caregivers see a red allergy alert wristband, they would likely be prompted to stop and double-check if the patient is allergic to medications, food or the treatment about to be delivered.

Q: Should the patient’s allergies be written on the allergy wristband?
A: No. It is advised that allergies be written in the medical record according to the hospital’s policy and procedure. Allergies should not be written on the wristband for several reasons:
- Legibility may hinder the correct interpretation of the allergy listed.
- It could be assumed that the list of allergies written on the alert wristband is all-inclusive. However, space is limited on a wristband and some patients may have several allergies. The risk of writing on the wristband is some allergies would be inadvertently omitted due to lack of space, which can lead to confusion or an assumption that the list is comprehensive.
- Throughout a hospitalization, allergies may be discovered by other caregivers, such as dieticians, radiologists, pharmacists, etc. This information is typically added to the medical record and not always on a wristband. By having one source of information to reference, such as the medical record, staff members in all disciplines know where to add and review newly discovered allergies.

Q: Why was yellow selected for fall risk?
A: Research indicates yellow implies “caution,” such as the last color warning before a stop at a traffic light. In addition, the American National Standards Institute uses yellow to communicate “tripping or falling hazards.” The color yellow would alert caregivers to use caution with a patient who has a history of falls, dizziness and difficulty with balance, fatigue or dementia.
Q: Why use an alert band for fall risk?
A: When a patient is wearing a fall risk alert wristband, it notifies all hospital staff that the patient needs to be assisted when walking or getting up from a sedentary position. According to the Centers for Disease Control and Prevention (CDC), falls are of great concern for the aging American population. According to the CDC:

- More than one-third of adults age 65 or older fall each year.
- Older adults are hospitalized for fall-related injuries five times more often than for injuries resulting from other causes.
- Of those adults who fall, 20 to 30 percent suffer moderate to severe injuries that reduce mobility and independence and increase the risk of premature death.
- The total cost of all fall injuries for people age 65 or older in 1994 was more than $27 billion.
- By 2020, the total cost of fall injuries is expected to reach more than $44 billion. 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 annual number of hip fractures is expected to exceed 500,000 by the year 2040. As the aging population enters the acute care environment, the risk that is present must be considered, and everything possible should be done to communicate that risk to staff. For more information about falls and related statistics, visit www.cdc.gov/ncipc/factsheets/fallcost.htm.

Q: Who chose these colors?
A: The Tennessee standardization initiative is modeled after the original work done by the Pennsylvania Color of Safety Task Force, Arizona Hospital and Healthcare Association and the experiences of other states that have adopted standardized colors for patient alert wristbands. The American Hospital Association also has adopted these wristband colors and patient alert meanings.

Q: Can hospitals still use other colors for additional alert messages?
A: THA’s standardization efforts mirror the national consensus and AHA recommendations. Hospitals should attempt to limit the number of colored bands used to high alert messages—the more colors used, the higher risk for confusion. If additional colored wristbands are used, pink is suggested for “restricted extremity” and green for “latex allergy.”

Q: Our hospital only uses wristbands for two of the alerts—allergy and falls. We don’t use wristbands for DNR. Can we participate without adopting all three alerts?
A: Yes. Hospitals are encouraged to use the standardized colors and meanings for the wristband alerts they currently use in their organization. If a hospital uses only one or two of the alerts, they do not have to add additional wristband alerts.

Q: What if a hospital uses red for blood bank wristbands too?
A: Some hospitals are currently using red wristbands for blood bank information which generally contain important patient identification information and blood specifications. Under Tennessee wristband standardization guidelines, a red allergy wristband contains no other text than the word “allergy”. Other than the color, the wristbands do not have similar characteristics and would be difficult to confuse. If a clinician is searching for blood bank information, it will not appear on an allergy wristband, prompting the clinician to look for a blood band wristband or locate the patient’s medical record. If a clinician notices a blood bank wristband and questions whether it indicate an allergy, the clinician should follow best practice and refer to the patient’s medical record to verify what, if any, allergies the patient may have. Each individual hospital should decide on the most appropriate course of action for their facility’s needs.

Q: In our community chronic kidney disease clients wear red-orange rubber wristbands that say “Save the Vein-No IV/Lab Sticks”. Should these be removed for acute care admissions?
A: Care should be taken to note the restricted extremity and document the need for restricted extremity access on assessment in accordance with your organization’s policies and procedures. It is recommended that these community wristbands be removed during any acute care inpatient admission and the wristband returned to the patient/family in keeping with the Tennessee color-coded wristband alert initiative recommendations. There is a high-risk of confusion between these restricted extremity alert bands and the hospitals’ standardized use of red color-coded wristbands for allergy alerts. If hospitals use color-coded wristbands for “restricted extremity”, pink is the recommended color.

THA Staff Contacts
Members with questions regarding the various activities related to wristband standardization should contact one of the following THA staff members:

**Color-Coded Patient Alert Wristband Standardization:**
Chris Clarke     Darlene Swart  
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(615)401-7437      615-401-7460

**Media:**
Beth Atwood  
batwood@tha.com  
(615) 256-8240
Implementation Considerations

Organizational Approval—

*Review:* Adoption may require approval by certain groups, including:

- Patient Safety Committee
- Quality Improvement Council
- Medical Staff Committee
- Board of Directors
- Director of Education
- Risk Management

*Action Plan:* Facilities may have different committees that need to approve changes that directly impact patient care. Each facility needs to assess which committees need to approve the adoption of the initiative. Remember to consider the stakeholders and be sure they understand and approve the initiative before it is implemented.

Materials Management Supply Assessment and Purchase—

*Review:* Assessment of current supply and wristband procurement.

*Action Plan:*

- Most organizations have a vendor in place to fill wristband orders. It is important to communicate to vendors that you are standardizing your color-coded alert wristbands to conform to the specifications included in this toolkit. Many vendors may be aware of this initiative and what specific colors need to be used to be in compliance with the standardization.

- The THA is not recommending Tennessee hospitals use a particular vendor. Rather, hospitals are encouraged to work with their existing vendor.

- Coordinate with your materials management department to evaluate the current stock of out-of-date color-coded wristbands, and approximate the time when new color-coded wristbands can be introduced.
Hospital Specific Documentation—

Review: Policy adoption, assessment revision, forms revised to meet standards, and consents.

Action Plan:

- The color-coded patient alert wristband policy should be reviewed and approved if changes are made.
- Hospitals should review their respective forms for possible modifications (patient education assessments, etc.).
- You may want to include language that the patient received in the wristband education brochure (see Staff/Patient Education materials).
- If a patient refuses to wear an alert wristband, there should be written documentation of refusal.
- Make certain to coordinate with risk management staff and individual hospital administrators.

Staff and Patient Orientation, Education, and Training—

Review: Schedule staff training, documentation requirement, and FAQs.

Action Plan:

- Education format and training materials need to be reviewed. Staff education materials and a competency form have been provided in this toolkit. The competency form may be customized to suit each hospital’s unique needs.
- Education of hospital staff will need to be scheduled and documented per hospital policy.
- Ensure that new employee orientation procedures include wristband education.

Implementation—

Review: Take measures to prepare for hospital’s standardization “Go Live” date.

Action Plan:

1. Include article in hospital newsletter(s) alerting all staff of the new patient alert wristband standardization policy.

2. In the weeks leading up to “Go Live” date, remind all hospital staff of impending standardization at regular intervals (staff meetings, rounds, etc.) and summarize alert wristband colors, their designated meanings, and policies and procedures that will be adopted in accordance with the standardization.
3. On the evening before the “Go Live” date, remove all the hospital’s stock of old wristbands and replace with new, standardized alert wristbands.

4. Designate hospital staff to review the medical chart and apply appropriate alert wristbands to patients on day of standardization.

5. On “Go Live” date, ensure correct alert wristband signage is posted at nursing stations.

6. On “Go Live” date, designated staff should review medical charts of all patients for medical conditions or wishes requiring a red (allergy), yellow (fall risk), and/or purple (do-not-resuscitate) alert wristband.

7. Prior to alert wristbands being applied to patients, staff should remove any/all social cause wristbands present on the patient, keeping in mind patient/family education and refusal procedures.

8. Alert wristbands should be applied to patients as appropriate, keeping in mind patient/family education and refusal procedures.

9. Supervisors should review alert wristbands that have been placed on patients for accuracy.

10. Hospital staff responsible for applying alert wristbands to patients should contact hospital’s Materials Management leadership once all alert wristbands have been applied to patients to make them aware of future inventory needs.

11. Two to four weeks after “Go Live” date, follow-up meetings should be scheduled with clinical leadership and other hospital staff involved in patient care to review patient alert wristband policy and procedure to gauge the standardization’s effectiveness.

12. Collect input from hospital staff and pursue necessary improvements to patient alert wristband policy and procedure.
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<th>Week 8</th>
<th>Week 9</th>
<th>Week 10</th>
<th>Week 11</th>
<th>Week 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify staff person who supports committee meetings and obtain contact information for each committee</td>
<td>X</td>
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<tr>
<td>Verify committee meeting times and seek space on agenda to present initiative</td>
<td></td>
<td>X</td>
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<tr>
<td>When initiative is approved, contact appropriate staff members to initiate action and convey information to staff</td>
<td></td>
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<td>X</td>
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<tr>
<td>Inform materials manager about upcoming initiative and provide access to the toolkit</td>
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<td>X</td>
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<tr>
<td>Inquire with materials manager about current wristband supply and when it will be depleted</td>
<td></td>
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<td></td>
<td>X</td>
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<tr>
<td>Assure materials management staff that they will be informed when approval for new product order is obtained</td>
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<tr>
<td>Request that the materials manager contact the facility's wristband vendor to alert of the pending change in product order</td>
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<tr>
<td>Task</td>
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<tr>
<td>Follow-up with materials management and confirm that the vendor has been contacted</td>
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<tr>
<td>Contact CNO and clinical directors to review records for information about wristbands</td>
<td>✔️ ✔️</td>
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<tr>
<td>Update any references to wristband colors that appear in records to reflect newly standardized colors</td>
<td>✔️ ✔️</td>
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<tr>
<td>If changes are required, contact forms committee and clinical directors to initiate changes.</td>
<td>✔️ ✔️</td>
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</tbody>
</table>
**THA COLORCODED PATIENT ALERT WRISTBAND STANDARDIZATION**

**Patient Alert Wristband Standardization Task Chart**

<table>
<thead>
<tr>
<th>Task</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
<th>Week 6</th>
<th>Week 7</th>
<th>Week 8</th>
<th>Week 9</th>
<th>Week 10</th>
<th>Week 11</th>
<th>Week 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review policy and procedure (P&amp;P) for wristband application</td>
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<tr>
<td>Contact clinical directors to ensure consistency in P&amp;P across departments</td>
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<tr>
<td>Secure approval of changes in P&amp;P</td>
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<tr>
<td>Become familiar with training content and tools</td>
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<tr>
<td>Discuss education rollout format with clinical directors</td>
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<tr>
<td>Contact appropriate committee to review patient education brochure</td>
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<tr>
<td>Contact trainers and announce train-the-trainer sessions</td>
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<tr>
<td>Replicate staff education section of toolkit for each trainer</td>
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<tr>
<td>Contact trainers to ensure proper preparation of educational materials for staff</td>
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<tr>
<td>Hold train-the-trainer sessions</td>
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<tr>
<td>Hold staff education sessions</td>
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<tr>
<td>Contact hospital public relations and marketing staff to prepare media and community communications</td>
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<tr>
<td>Launch media and community communications</td>
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<tr>
<td>Implement patient alert wristband standardization</td>
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</tbody>
</table>
#1 – Organizational Approval and Awareness

## STEP 1

### What to do

Identify the staff person who supports the following committee meetings. Obtain contact information for each one:

- Patient Safety Committee
- Medical Staff Committee
- Quality Improvement Council
- Board of Directors
- Risk Management
- Other?

**Note:** Not all committees will need to approve this initiative; however, they may benefit from a presentation that provides information so they can support it. Seek guidance from your administrative team to determine which meetings should receive the presentations.

### Notes – Comments – Follow-ups

<table>
<thead>
<tr>
<th>Committee</th>
<th>Name</th>
<th>E-mail/Ext.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Staff Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Improvement Council</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board of Directors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

## STEP 2

### What to do

Find out when meetings are and seek time on the agenda to present the initiative for purposes of acquiring or conveying information.

**Note:** Not all committees will need to approve this initiative; however, they may benefit from a presentation that provides them information so they can support it. This is equally important and should be considered a priority.

### Notes – Comments – Follow-ups

<table>
<thead>
<tr>
<th>Committee</th>
<th>Meeting Date</th>
<th>On agenda? (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Staff Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Improvement Council</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board of Directors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### STEP 3

<table>
<thead>
<tr>
<th>What to do</th>
<th>Notes – Comments – Follow-ups</th>
</tr>
</thead>
<tbody>
<tr>
<td>After presentations are made and implementation of the program is approved, contact appropriate departments and staff members to initiate action/convey information.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Department</th>
<th>Information to be Conveyed</th>
<th>Follow-ups</th>
</tr>
</thead>
</table>
| Materials Management | 1. Committee approvals obtained.  
2. Approval to order wristbands.  
3. When will wristbands be available? Take that date and add five to seven more days. That is your “Go Live” date. (The five to seven additional days allow for distribution of wristbands to pertinent areas.) | How long until delivery? |
| Staff Education | 1. Wristbands will be arriving in about ___ weeks.  
2. OK to start education.  
3. “Go Live” date is _______. | When will education occur? |
| Risk Management and/or Quality Improvement Director | 1. Wristbands will be arriving in about ___ weeks.  
2. “Go Live” date is _______.  
3. Confirm that policy and procedure have been approved and start preparation for add-ins to Policies and Procedures manual. | |
| Other departments to consider: Medical Staff, Admitting, Emergency, Peri-Operative, Nursing, Dietary, Laboratory, Radiology, Pharmacy, etc. | 1. Wristbands will be arriving in about ___ weeks.  
2. OK to start education.  
Coordinate with education department for materials, training and information.  
3. “Go Live” date is _______. | |

### #1 – Organizational Approval and Awareness

| Date Completed | / | / | / |
#2 – Supplies Assessment and Purchase

## STEP 1

<table>
<thead>
<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Materials Manager on the initiative. Answer questions and share the toolkit.</td>
<td>Coordinate with the Materials Management contact who will place the order:</td>
</tr>
<tr>
<td></td>
<td>Name: ________________________________________________________________________</td>
</tr>
<tr>
<td><strong>Remember:</strong> You are just gathering information. Do not order wristbands until organizational approval has been obtained.</td>
<td>Email: ______________________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>Telephone: __________________________________________________________________</td>
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</tbody>
</table>

## STEP 2

<table>
<thead>
<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask Materials Manager when current supply of wristbands will be depleted. This is based on estimates from typical order patterns and staff usage.</td>
<td>Allergy bands depleted about ________________________ (ex. mid-January 09)</td>
</tr>
<tr>
<td></td>
<td>Fall bands depleted about __________________________________________________________________</td>
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<tr>
<td></td>
<td>DNR bands depleted about __________________________________________________________________</td>
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</tbody>
</table>

## STEP 3

<table>
<thead>
<tr>
<th>What to do</th>
<th>When to do it</th>
<th>Other Notes/Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assure Materials Management staff that you will contact them to order wristbands once organizational approval has been obtained and Policy and Procedure changes have been approved</td>
<td>Give status report within a month of initial contact so Materials Management knows this still is being worked on.</td>
<td></td>
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</table>
### STEP 4

<table>
<thead>
<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
</tr>
</thead>
</table>
| Ask Materials Manager to contact wristband vendor and alert to the pending change in supply color. Convey the information in the next column, and check off items as they are communicated to vendors. | **Allergy band:**  
- Red: PMS 1788  
- “ALLERGY” pre-printed on the band in black – 48 pt. Arial Bold, all caps  

**Fall Band:**  
- Yellow: PMS 102  
- “FALL RISK” pre-printed on band in black – 48 pt. Arial Bold, all caps  

**DNR Band:**  
- Purple: PMS 254  
- “DNR” reversed out on band in white – 48 pt. Arial Bold, all caps |

### STEP 5

<table>
<thead>
<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
</tr>
</thead>
</table>
| Follow-up with Materials Management in one week and validate that the vendor has been contacted. Complete the information obtained from the Materials Manager in the next column. | Lead time required when ordering wristbands is:  
**Allergy band:** ________ weeks  

**Fall band:** ________ weeks  

**DNR band:** ________ weeks |

**#2 – Supplies Assessment and Purchase**  
| Date Completed | / | / | / |
#3 – Hospital-Specific Documentation

## STEP 1

<table>
<thead>
<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact chief nursing officer and clinical directors to review if</td>
<td>Coordinate with chief nursing officer and clinical directors.</td>
</tr>
<tr>
<td>documentation records contain specific information about wristbands,</td>
<td>It may be helpful or more efficient to pull the daily documentation</td>
</tr>
<tr>
<td>such as daily nursing charting.</td>
<td>information for the various areas and review the current requirement.</td>
</tr>
<tr>
<td><strong>Remember:</strong> This is not a recommendation to add “wristbands” to your</td>
<td>Consider these documents:</td>
</tr>
<tr>
<td>documentation process or color-specific information, but to review your</td>
<td>• ER Triage Record or Treatment/ER Nurses Notes</td>
</tr>
<tr>
<td>current documents/process.</td>
<td>• Admitting Assessment</td>
</tr>
<tr>
<td></td>
<td>• Intensive Care Units Nurses Notes</td>
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<tr>
<td></td>
<td>• Peri-Operative Assessments or Notes</td>
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<tr>
<td></td>
<td>• Daily Nursing Documentation</td>
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<td>• Other: ______________________________________________________________________</td>
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## STEP 2

<table>
<thead>
<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
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</thead>
<tbody>
<tr>
<td>If current documentation addresses wristband information, review documents</td>
<td>This is not a recommendation that the documentation reflect color information</td>
</tr>
<tr>
<td>to ensure any reference to colors is updated to reflect these changes.</td>
<td>about wristbands. However, if your documentation is color-specific, this is a</td>
</tr>
<tr>
<td></td>
<td>cue to validate that the information be updated to reflect the new colors – if</td>
</tr>
<tr>
<td></td>
<td>that is your current process.</td>
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</table>

## STEP 3

<table>
<thead>
<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
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</thead>
<tbody>
<tr>
<td>If changes are required to the documentation forms, contact the forms</td>
<td>Some organizations require any changes to forms be reviewed through a</td>
</tr>
<tr>
<td>committee and pertinent clinical directors and initiate the process for</td>
<td>“forms committee” or similar entity. Other organizations do not require this</td>
</tr>
<tr>
<td>changes.</td>
<td>process if the information being changed is minimal and does not change</td>
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<tr>
<td></td>
<td>“content.” This step is to determine your organization’s process.</td>
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</tbody>
</table>
### STEP 4

<table>
<thead>
<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
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</thead>
<tbody>
<tr>
<td>Once the process is known, and if a form(s) update is required, factor the print time and new form availability into the timeline so the education and implementation processes are coordinated with the arrival of new documentation.</td>
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</table>

### STEP 5

<table>
<thead>
<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
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</thead>
<tbody>
<tr>
<td>The policy and procedure (P&amp;P) for wristband application needs to be reviewed and updated to reflect the new process. Obtain a copy of the current wristband P&amp;P and review content.</td>
<td>A sample P&amp;P has been provided to use as a template. Review this sample and adopt its content as appropriate in your organization.</td>
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### STEP 6

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<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
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<tbody>
<tr>
<td>Some banding processes may vary slightly within the organization given the area of care and its unique needs, such as Emergency Room, Peri-Operative, Radiology, Labor and Delivery, etc. Contact the directors of these areas to determine if each has a specific policy and procedure or if the hospital’s general policy and procedure is followed. Review any needed changes in specific policy and procedure with the respective director.</td>
<td>Emergency Room Director, Name/Ext: ____________________________________________ Unique P&amp;P? No________ Yes________ (obtain copy)</td>
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<tr>
<td></td>
<td>Peri-Operative Director, Name/Ext: ____________________________________________ Unique P&amp;P? No________ Yes________ (obtain copy)</td>
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<tr>
<td></td>
<td>Radiology Director, Name/Ext: ________________________________________________ Unique P&amp;P? No________ Yes________ (obtain copy)</td>
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<tr>
<td></td>
<td>Labor and Delivery Director, Name/Ext: _________________________________________ Unique P&amp;P? No________ Yes________ (obtain copy)</td>
</tr>
<tr>
<td></td>
<td>“Other” Director, Name/Ext: _________________________________________________ Unique P&amp;P? No________ Yes________ (obtain copy)</td>
</tr>
<tr>
<td></td>
<td>“Other” Director, Name/Ext: _________________________________________________ Unique P&amp;P? No________ Yes________ (obtain copy)</td>
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## STEP 7

<table>
<thead>
<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
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</thead>
<tbody>
<tr>
<td>Secure placement of the wristband application changes on the agenda of the P&amp;P Committee. Coordinate this with the departments that have “unique” P&amp;P so all are considered the same.</td>
<td>P&amp;P Committee Contact/Ext: ____________________________</td>
</tr>
<tr>
<td>Secure approvals of changes in your organizations operating policy and procedure.</td>
<td>Date/Month on P&amp;P Committee Agenda: ____________________________</td>
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<td></td>
<td>Communicate the P&amp;P Committee date to other pertinent directors so the proposed changes are reviewed and agreed upon in advance.</td>
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</table>
#4 – Staff and Patient Education

## STEP 1

<table>
<thead>
<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
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</thead>
<tbody>
<tr>
<td>Become familiar with training content and tools (FAQs, brochures, posters, etc.).</td>
<td>Review the content of the education section in this toolkit. This is important because as discussions occur about who will do what, you can inform the directors about the tools that are available for staff to use. Because the education section is comprehensive, some may opt to participate in the facilitation process. By giving directors all of the information about the tools and training section in this manual, they can make a better and informed decision.</td>
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## STEP 2

<table>
<thead>
<tr>
<th>What to do</th>
<th>Other Notes/Cues</th>
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</table>
| Discuss the education format with the education department and clinical directors to determine if education is going to be managed at the unit-specific level or in a general session where multiple departments are present. Is education going to be facilitated by department-specific directors or the education department? | Education Department Preferences are: Unit-Specific__General Session__  
Other: (explain): ________________________________________________  
Facilitator Preferences: Unit-Based____ Education Department_____  
Critical Care Director Preferences are: Unit-Specific__General Session__  
Other: (explain): ________________________________________________  
Facilitator Preferences: Unit-Based____ Education Department_____  
Med/Surg Director Preferences are: Unit-Specific__General Session__  
Other: (explain): ________________________________________________  
Facilitator Preferences: Unit-Based____ Education Department_____  
Pharmacy Director Preferences are: Unit-Specific__General Session__  
Other: (explain): ________________________________________________  
Facilitator Preferences: Unit-Based____ Education Department_____ |

It is important to consider all of the stakeholders: physicians, dietary, pharmacy, therapies, radiology, peri-operative, ER, labor & delivery, housekeeping, volunteers, students, etc.
### STEP 3

<table>
<thead>
<tr>
<th><strong>What to do</strong></th>
<th><strong>Other Notes/Cues</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain the names of the trainers and send an e-mail advising them of an upcoming Train-the-Trainer session. This meeting should be no longer than one hour. Schedule this about one month in advance to accommodate already full schedules</td>
<td>Whether training occurs at a unit-based level or in a general session, a Train-the-Trainer session should be considered so the education materials and training tips can be reviewed by all and used consistently.</td>
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</tbody>
</table>

### STEP 4

<table>
<thead>
<tr>
<th><strong>What to do</strong></th>
<th><strong>Other Notes/Cues</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact the chair of the “patient/community education” committee and schedule an appointment to review the patient brochure and wording to add to the hospital’s patient handbook distributed upon admission. If necessary, secure a place on the agenda of the next committee meeting to obtain approval for the brochure and handbook wording to be used.</td>
<td>Another component to the education section is patient education. Most organizations have a “patient/community education” committee that reviews education materials before their use.</td>
</tr>
</tbody>
</table>

### STEP 5

<table>
<thead>
<tr>
<th><strong>What to do</strong></th>
<th><strong>Other Notes/Cues</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Make one copy of the education section of this toolkit for each trainer so each has his/her own set of materials. Include the PowerPoint® presentation. Some organizations may want to put the PowerPoint® on a shared drive, while others may want to burn a copy of the CD.</td>
<td></td>
</tr>
<tr>
<td>STEP 6</td>
<td>What to do</td>
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</tr>
<tr>
<td>Send an e-mail to all trainers reminding them to make copies of the following handouts for their staff.</td>
<td></td>
</tr>
<tr>
<td>• Staff education brochure</td>
<td></td>
</tr>
<tr>
<td>• Patient education brochure</td>
<td></td>
</tr>
<tr>
<td>• FAQs</td>
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<tr>
<td>• Posters announcing the meeting</td>
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<tr>
<td>• Sign-in sheet</td>
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<tr>
<td>• Competency checklist (if appropriate)</td>
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</table>

<table>
<thead>
<tr>
<th>STEP 7</th>
<th>What to do</th>
<th>Other Notes/Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact your hospital’s public relations/marketing staff regarding communication about the color-coded wristband program. Identify target audiences in the hospital and the community and communication tools to reach them</td>
<td></td>
<td>A sample news release is provided in the education section of this toolkit. It can be used as an article in your hospital’s publications.</td>
</tr>
</tbody>
</table>

#4 – Staff and Patient Education | Date Completed | / | / | / |
<table>
<thead>
<tr>
<th>#5 – Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP 1</strong></td>
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<td><strong>STEP 2</strong></td>
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<td><strong>STEP 3</strong></td>
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<td><strong>STEP 4</strong></td>
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<td><strong>STEP 5</strong></td>
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<td><strong>STEP 6</strong></td>
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<thead>
<tr>
<th><strong>STEP 7</strong></th>
<th><strong>What to do</strong></th>
<th><strong>Other Notes/Cues</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prior to alert wristbands being applied to patients, staff should remove any/all social-cause wristbands present on the patient, keeping in mind patient/family education and refusal procedures.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>STEP 8</strong></th>
<th><strong>What to do</strong></th>
<th><strong>Other Notes/Cues</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alert wristbands should be applied to patients as needed, keeping in mind patient/family education and refusal procedures.</td>
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</table>

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<thead>
<tr>
<th><strong>STEP 9</strong></th>
<th><strong>What to do</strong></th>
<th><strong>Other Notes/Cues</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Supervisors should review alert wristbands that have been placed on patients for accuracy.</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th><strong>STEP 10</strong></th>
<th><strong>What to do</strong></th>
<th><strong>Other Notes/Cues</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital staff responsible for applying alert wristbands to patients should contact hospital’s Materials Management leadership once all alert wristbands have been applied to patients to make them aware of future inventory needs.</td>
<td></td>
</tr>
<tr>
<td><strong>STEP 11</strong></td>
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<tr>
<td><strong>What to do</strong></td>
<td><strong>Other Notes/Cues</strong></td>
<td></td>
</tr>
<tr>
<td>Two to four weeks after “Go Live” date, follow-up meetings or discussions should be scheduled with clinical leadership and other hospital staff involved in patient care to review Patient Alert Wristband policy and procedure to gauge the standardization’s effectiveness.</td>
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<td></td>
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</tbody>
</table>

| **STEP 12** | | |
|---|---|
| **What to do** | **Other Notes/Cues** |
| Collect input from hospital staff and pursue necessary changes to Patient Alert Wristband policy and procedure. | |

<table>
<thead>
<tr>
<th><strong>#5 – Implementation</strong></th>
<th><strong>Date Completed</strong></th>
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</table>
Sample Content for Hospital Policies and Procedures

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

**Objectives:**

- Reduce the risk of confusion associated with the use of color-coded alert wristbands.
- Communicate patient safety risks to all healthcare providers.
- Include the patient, family members and significant others in the communication process and promote safe health care.
- Adopt the following risk reduction strategies:
  - A preprinted descriptive text is used on the bands clarifying the intent (i.e., “ALLERGY,” “FALL RISK” or “DNR”).
  - Hospital staff should not write on the alert wristband.
  - Color-coded alert wristbands only may be applied or removed by a nurse or designated staff person conducting an assessment.
  - 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 label text (if applicable) of the color-coded alert wristband.
  - “Social cause” or other non-facility community wristbands, such as the “LIVESTRONG” and other causes, should not be worn in the hospital setting. This is to avoid confusion with the color-coded alert wristbands and enhance patient safety.
  - Allow the patient and family members to be a partner in the care provided and safety measures being used.

The following represents the meaning of each color-coded alert wristband:

<table>
<thead>
<tr>
<th>Wristband 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>Purple</td>
<td>DNR</td>
</tr>
</tbody>
</table>
Identification (ID) Bands in Admission, Pre-Registration Procedure and/or Emergency Department:

The standard admission identification (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 Patient Alert Wristbands:

During the initial patient assessment, data is collected to evaluate the needs of the patient and a plan of care unique to the individual. 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/or DNR status are identified or modified. Because this is an interdisciplinary process, it is important to identify staff members responsible for applying and removing color-coded alert wristbands, how this information is documented and how it is communicated.

The following procedures have been established to remove uncertainty in these processes:

- Any patient demonstrating risk factors on initial assessment will have a color-coded alert wristband placed on the same extremity as the admission ID band by the nurse or designated staff member.
- The application of the wristband is documented in the patient’s medical chart by hospital staff, per hospital policy.
- If labels, stickers, or other visual cues are used to document in the medical record, these alternative cues should correspond to the alert wristband color and text label.
- Upon application of the color-coded wristband, the nurse or designated staff member will instruct the patient and family member(s) (if present) that the wristband is not to be removed.
- In the event that any alert wristband(s) must be removed for a treatment or procedure, a nurse or designated staff member will apply new wristbands to another extremity prior to removing the wristbands already in place. Upon completion of the treatment, risks will be reconfirmed and the alert wristbands will be replaced appropriately on the patient.

“Social Cause” or Other Non-Facility Community Wristbands:

- Following the patient ID process, a designated staff member examines the patient for “social cause” wristbands.
- If “social cause” wristbands are present, the designated staff member 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 designated staff member will request that the patient sign a refusal form acknowledging the risks associated with the “social cause” wristbands. In the event that the patient is unable to provide permission, and a family member or significant other also is not present, the designated staff member may remove the “social cause” wristbands in order to reduce the potential for confusion or harm to the patient.

**Patient/Family Involvement and Education:**

It is important that the patient and their family members are informed about the care provided in the hospital setting. It also is important that the patient and family member(s) are acknowledged as a valuable member of the healthcare team. Including patients and/or family member(s) in the process of using color-coded alert wristbands will assure a common understanding of what the alert wristbands mean, how care is provided when the alert wristbands are worn, and the patient’s/family’s role in correcting any information that contributes to this process. Therefore, during assessment procedures, the designated staff member should take the opportunity to educate the patient and their family members about:

- The meanings of the alert wristbands and the medical condition associated with each wristband.
- The risks associated with wearing “social cause” wristbands and why these bands should be removed.
- To notify the hospital staff whenever a wristband has been removed and not reapplied, or when a new wristband is applied and the patient and/or family has not been given an explanation as to the reason.
- Patients and families also should be given a patient/family education brochure that explains this information.

**Hand-Offs:**

- The nurse will reconfirm color-coded alert wristbands before invasive procedures, during patient transfers, and during change of shift with patients and/or family members, as well as other caregivers.
- Discrepancies in information must be investigated and corrected immediately.
- Color-coded alert wristbands should *not* be removed at discharge.
- For home discharges, the patient is advised to remove the wristband at home.
- For discharges to another facility, the wristbands should not be removed during transfer. Receiving facilities should follow their own wristband policies and procedures.
DNR (Do-not-resuscitate):

- DNR (do-not-resuscitate) status and all other risk assessments are determined by individual hospital policy, procedure and/or physician order written and acknowledged within that care setting only.
- The color-coded alert 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 patient alert wristbands will occur during the new orientation process and reinforced as indicated.
- Hospitals should consider inserting language that addresses how staff competency is assessed if a decision is made to include color-coded patient alert wristbands as a competency for staff or selected staff.

Patient Refusal:

- If the patient is capable and refuses to wear the color-coded alert wristband, an explanation of the risks will be provided to the patient and/or family.
- The designated staff member will reinforce that it is the patient’s and/or family’s opportunity to participate in an effort to prevent medical errors, and it is their responsibility as part of the healthcare team.
- The designated staff member will document patient refusals in the medical record, and include the explanation provided by the patient or their family member.
- The patient will be asked to sign a refusal form.
Sample Patient Refusal Form

Include relevant patient identification on this form as specified per hospital policy.

Patient Refusal to Participate in Hospital’s Color-Coded Alert Wristband Policy

The above named patient has refused to follow the recommendations of the hospital staff as it relates to [facility name]’s color-coded alert wristband policy.

I, ___________________________________, have refused the following recommendations:

☐ To wear a color-coded alert wristband that would alert medical staff about a medical condition that I have. The benefits of the use of color-coded wristbands have been explained to me by a member of the healthcare team. I understand the benefits of the use of color-coded alert wristbands and despite this information, I do not give permission for the use of color-coded alert wristbands in my care.

☐ To remove a personal “social cause” wristband (e.g. “LIVESTRONG”) while I am a patient at this facility. The risks of refusing to remove the “social cause” colored wristband(s) have been explained to me by a member of the healthcare team. I understand that refusing to remove the “social cause” wristband(s) could cause confusion in my care and, despite this information, I do not give permission for its/their removal.

Reason(s) provided by patient (if any):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________

The benefits of the use of the color-coded patient alert wristbands have been explained to me by a member of the hospital staff. However, I do not give my permission to wear the color-coded alert wristbands that would alert hospital staff to my medical condition(s) and/or refuse to remove a colored “social cause” wristband(s) that may cause confusion with medical alert wristbands.

_____________________________________________________________________
Patient/Delegate Signature Date

_____________________________________________________________________
Hospital Staff Signature Date
Staff Education

The following section regarding staff education has been developed to facilitate implementation of the patient alert wristband standardization project in Tennessee hospitals and other healthcare facilities. Facilities may select those materials they believe would be most beneficial in assisting in the education of staff at their institutions or elect to modify the materials presented.

The decision on how to implement standardized patient alert wristbands will be unique to each hospital, and the education process can be either formal or informal. Suggested methods that can be used to ensure staff receive the appropriate education and training include unit or department staff meetings, education sessions, online modules and annual competency checklists. Organizations should consider introducing new staff to the hospital’s policies and procedures related to use of color-coded patient alert wristbands during initial hospital orientation.

A sample PowerPoint® presentation and sample brochure that can be used with hospital staff is available on the THA web site at www.tha.com and the Tennessee Center for Patient Safety web site at www.tnpatientsafety.com.

Preparation for Getting Started: Identify Other Key Participants

- While nurses will likely be the designated staff person placing alert wristbands on patients, remember that unit clerks may be involved in the process as well. For example, as unit clerks compile the medical record or review orders, they might assist the nurse in identifying particular medical conditions that warrant the use of a color-coded patient alert wristband.

- Remember to educate environmental service staff as they often are present in patient rooms. If environmental service staff is made aware that yellow alert wristbands signify a patient is at risk for falls, they can alert appropriate staff and help prevent patient harm or injury.

- Remember to educate dietary staff. A red alert wristband indicates the patient has some type of allergy, which may not be limited to medications. A red alert wristband could alert dietary staff to consider whether the patient has food allergies.

- Consider other staff throughout the facility where patients may undergo diagnostic testing or other procedures. They should be aware of what the patient alert wristband colors mean and how they will act on that visual cue in their respective departments before performing scheduled tests or procedures.
• Do not make assumptions that the entire hospital staff has knowledge of the color-coded patient alert wristbands. Be sure to consider medical staff, residents and students who provide care to patients.

Getting Started

• **Start with a Story.** Individuals need to know why they should do something; simply telling them they need to adopt a practice “because it is hospital policy” is not sufficient to achieve high levels of compliance. A story can provide context and help hospital staff understand why it is important to comply with hospital policies and procedures.

  > In December 2005, the Pennsylvania Patient Safety Authority issued an advisory based on an incident or “near miss” report. This advisory, which has received national attention, described an incident that occurred in a Pennsylvania hospital in which clinicians nearly failed to rescue a patient experiencing a cardiopulmonary arrest. The source of the confusion was a nurse who had incorrectly placed a yellow wristband on the patient.

  > In the hospital where the patient was admitted, a yellow wristband meant “do-not-resuscitate.” However, at a nearby hospital where the nurse was also employed, a yellow wristband meant “restricted extremity,” which is what the nurse wanted to alert hospital staff about. Fortunately, another nurse recognized the mistake, and the patient was resuscitated.

  > This “near miss” occurrence highlights a potential source of confusion and an opportunity to improve patient safety by reevaluating the use of color-coded wristbands. This event also underscores the importance of bringing near miss events to the attention of the hospital so that all such health care providers can learn from these events.

  > Since this event, there have been national efforts to adopt a standardized set of colors that all hospitals and other health care providers should use to indicate certain medical conditions.

• **Stress the “Big Picture” on Compliance with Standardization.** Providing context for why it is important to participate in a statewide effort may provide incentive for compliance. Explain to staff that this initiative is part of a statewide and national effort aimed at standardizing the colors of patient alert wristbands. Organizations may elect to use this as an opportunity to explain more about how standardization can make a huge impact on improving patient safety and encourage staff to consider other processes of care that would be amenable to standardization across the organization.

• **Introduce the Colors.** Review with staff the three wristbands, color designation and corresponding meaning.
NOTE: Even though Tennessee hospitals may use different vendors, it is important to use the same color shade for each alert wristband as designated in this toolkit.

- **Utilize the Other Parts of this Toolkit.** Use the Frequently Asked Questions section to explain why certain colors were selected.

- **Stress the Risk Reduction Strategies.** The risk reduction strategies included throughout this document should be shared with hospital staff.

- **Explain the Process for Educating Patients.** You can mention to staff that there is a patient/family education brochure that can be used if you believe your organization would find this useful. The following is a sample script that can be used by staff when talking to a patient or family members.

**Q. What is a color-coded patient alert wristband?**

A. Color-coded patient alert wristbands are used in hospitals to quickly communicate a patient's health care status or medical condition. Alert wristbands are used by hospital staff to help provide the best possible care.

**Q. What do the colors mean?**

A. RED means ALLERGY; YELLOW means FALL RISK; and PURPLE means DO-NOT-RESUSCITATE

- **ALLERGY** – If a patient has an allergy to anything, including food, medicine, dust, grass, or animals, please tell us. Knowledge of any type of allergy could be very important to the care that a patient receives.

- **FALL RISK** – Our hospital wants to prevent falls at all times. Nurses assess patients all the time to determine if they need extra help and attention in order to prevent a fall. Sometimes, a person may become weakened during their illness or because they just had surgery. When a patient is wearing this wristband, it alerts all staff that the patient needs to be assisted when walking or getting up from lying down.

- **DNR** – Some patients have indicated that they would prefer that certain measures to extend life, such as trying to resuscitate them if they stop breathing, not be performed. It is our responsibility to ensure that we honor these kinds of decisions that have been made by patients when they seek care at our facility.
• **Review with Staff the Following Key Points.** The items listed below are part of the competency expectations associated with this initiative. Therefore, it is important that hospital staff has a good understanding of these key points. If your hospital policy will be modified to include certain key points, make sure the competency form given to staff reflects these changes.

  • What do the colors mean?
  • Who can apply the wristband to the patient?
  • When in the course of care are wristbands applied?
  • What is hospital policy on the removal of “social cause” wristbands?
  • What is the process for patient education and how is this information conveyed to patients and families?
  • What is the policy on reapplication of wristbands?
  • What is the policy for communication of wristband use during patient transfers, handoffs or at change of shift?
  • What is the policy for patient refusal to comply with hospital wristband policy?
  • What is the policy for removal of wristbands prior to discharge of patients to home or other postacute care facilities?
Risk Reduction Strategies Staff Should Know

Color-Coded Patient Alert Wristbands/Risk Reduction Strategies

Quick Reference Card

1. Use wristbands with the alert message preprinted (such as DNR).
2. Remove any “social cause” colored wristbands (such as LIVESTRONG).
3. Remove wristbands that have been applied by another facility, except for emergency identification bands.
4. Initiate banding upon admission, changes in condition or receipt of information during the hospital stay.
5. Educate patients and family members regarding the wristbands.
6. Coordinate chart/white board/care plan/door signage information/stickers with same color coding.
7. Educate staff to verify color-coded patient alert wristbands upon assessment and during handoff of care and facility transfer communication.
Tennessee Hospital Association

Color-Coded Patient Alert

Wristband Standardization Initiative

Hospital/Health System Logo here
Why Standardize?

• In Pennsylvania, an error occurred when a nurse placed a yellow wristband on a patient to designate “restricted extremity.” However, yellow designated “do not resuscitate” in that hospital.

• When the patient experienced an arrest, resuscitation was delayed until another staff member noted the discrepancy and revived the patient.

• The nurse who applied the wristband worked in another facility where yellow designated “restricted extremity.”

• In Tennessee, hospitals currently use seven different colors of alert wristbands to indicate “do not resuscitate.”
Tennessee “Banding Together for Patient Safety”

- The Tennessee Center for Patient Safety is leading the implementation plans, with guidance from the THA Quality Committee.
- THA’s Board of Directors has endorsed this voluntary initiative.
Project Overview

• The Tennessee Center for Patient Safety is encouraging hospitals that use color-coded patient alert wristbands to standardize to three national consensus colors:
  – RED Allergy
  – YELLOW Falls
  – PURPLE Do Not Resuscitate (DNR)

• The goal is 100% standardization from hospitals that use wristband alerts by Dec 31, 2009.

• Hospitals that currently do not use wristbands are not being asked to begin.
2008 Tennessee Wristband Survey Results

- 84.6% of respondents use wristband alerts.
- Wristband alerts are used to communicate eight or more types of clinical information.
- In Tennessee, there is significant variation in the colors and meanings for safety alert wristbands.
- Only 54% use preprinted text (allergy, falls) on the colored wristbands.
- 98% of respondents indicated a willingness to change practices as part of a statewide standardization effort.
## Tennessee Wristband Standardization Survey

<table>
<thead>
<tr>
<th>Clinical Topic</th>
<th>Number (%) of facilities using wristbands</th>
<th>Dominant Color</th>
<th>Number of other colors used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>67%</td>
<td>Red 47%</td>
<td>4 or more</td>
</tr>
<tr>
<td>Falls</td>
<td>82%</td>
<td>Yellow 31%</td>
<td>6 or more</td>
</tr>
<tr>
<td>DNR</td>
<td>48% (52% do not use)</td>
<td>Blue 18%</td>
<td>7 or more</td>
</tr>
</tbody>
</table>
National Consensus

• Nearly 30 states have standardized or are currently in the process of implementation.
• Bordering states that have/are adopting wristband standardization:
  – Arkansas, Missouri, Mississippi, Alabama, South Carolina, North Carolina, Virginia, Kentucky
• AHA asked members to join this effort.
Standardized Wristband Colors

- **Allergy = RED**
  - ALLERGY should be printed or embossed on the wristband

- **Fall Risk = YELLOW**
  - “FALL RISK” should be printed or embossed on the wristband

- **Do Not Resuscitate (DNR) = PURPLE**
  - “DO NOT RESUSCITATE” or “DNR” should be printed or embossed on the wristband
Recommendations

- Wristbands should be embossed with printed text indicating the meaning, such as allergy, to reduce misinterpretation.
- Handwriting on wristbands should be avoided.
- If alert stickers, door signage or other ancillary means of communicating risk are used, consider using same color/text as wristbands.
Staff Education and Training

Authority for color-coded alert wristband application:

- During initial and reassessment procedures, review risk factors associated with falls, allergies and DNR
- The appropriately colored wristband is applied by the nurse on the same arm as the ID band(s)
- Application of the wristband(s) is documented in the chart according to hospital policy
Staff Education and Training

Wristband confirmation and use of supporting documentation:

- To reduce misinterpretation of the wristbands, they will be embossed with text to ensure readability.
- Handwriting on the wristbands should be avoided.
- Per specific hospital policy, “alert “stickers/labels may be used as an ancillary means of communicating the risk factors and will have a corresponding color and text.
Staff Education and Training

“Hand-off Communication:

– The nurse should reconfirm color-coded patient alert wristbands before invasive procedures, at transfer and during changes in level of care with the patient/family, other caregivers and the patient’s chart.
– Error and/or omissions are corrected immediately
– Hand-off communication must be documented
Staff Education and Training

Risk Reduction Strategies

• Limit use of color-coded wristbands to high alert medical conditions.
• Educate patients and their families about the purpose and meaning of the color-coded wristbands.
• Educate healthcare workers on the purpose and meaning of the color-coded wristbands, including how to ensure good communication about patient status during “hand-offs.”
Risk Reduction Strategies

• Remove wristbands that have been applied by staff in another facility.
• Remove “social cause” or other colored bands.
• Use wristbands with pre-printed text that clearly identify the alert.
• Make sure the wristbands reflect the current medical condition or status of the patient.
Staff Education and Training

Relocation of wristbands for treatment:

• In the event that any color-coded wristband(s) must be removed for the treatment of the patient, the nurse will:
  – Retrieve new wristband(s) from LOCATION
  – Place the new wristband(s) on another extremity (if necessary) and document the action
Staff Education and Training

Risk Reduction Strategies

• REMEMBER: Color-coded wristbands are simply a visual cue for staff and do not replace verification of information in the patient’s medical record.
Staff Education and Training

Risk Reduction Strategies

• Color-coded wristbands are not removed at discharge:
  – For home discharge, the patient is advised to remove the band when he/she is off hospital property.
  – For discharges or transfer to another facility, the wristbands are left intact as a safety alert for “hand-off” communication.
  – DNR status and all other risk assessments are determined by individual hospital policy and/or physician order written and acknowledged within that care setting only.
  – The receiving hospital/facility is responsible for reassessment and subsequent band removal, reconfirmation or application.
Patient Education

Educate the patient and their family members:
• About the meanings of the alert wristbands and the medical condition associated with each
• About the risks associated with wearing “social cause” wristbands and why these bands should be removed
• When a new wristband is applied and the reason
• Use a patient/family education brochure that explains this information, which is located _____
Implementation: “Go Live” Date

Our hospital “Go Live” date is __________

• Awareness efforts leading up the day will include (list examples such as newsletters, screensavers)
• Removal of old stock of non-standardized color-coded alert and replace with new, standardized color-coded wristbands will occur on DATE
• Designated staff will review medical charts before and after standardization
• Follow-up with staff to obtain feedback will occur via survey on DATE
Community Awareness

Other hospitals in our community are also transitioning to the standardized color-coded wristbands.

Stakeholders are being informed of this effort:

(LIST your community stakeholders notified such as other health care providers, long term care facilities, ambulance services, physician officers)
Conclusion

- Safety risks will be assessed and the appropriate color-coded wristband applied
- After the wristband is applied, caregivers must document that application in the patient’s record
- Frequently check the wristband and “hand-off” the information to other staff
- Education patient/family about the wristband and document the information provided
- Take appropriate steps if the patient is incapable or refuses a wristband such as explaining the potential risks and requesting the patient sign a refusal form
- You do not remove the bands when the patient is discharged
Acknowledgements

• THA’s Tennessee Center for Patient Safety was created to support and accelerate hospital adoption of best practices to improve patient safety and quality

• www.tnpatientsafety.com

THA thanks the Michigan Health and Hospital Association for allowing use and adaptation of their toolkit and resources for Tennessee
How did this get started?

In 2005, a hospital in Pennsylvania submitted a report to the Pennsylvania Patient Safety Reporting System 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 do-not-resuscitate.

The source of confusion was a nurse who incorrectly had placed a yellow wristband on the patient. In that hospital, a yellow wristband signified the patient should not be resuscitated. In a nearby hospital where the nurse also worked, yellow signified “restricted extremity,” meaning that this arm is not to be used for drawing blood or obtaining intravenous access. Fortunately, 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 patient alert wristbands.

Tennessee hospitals acknowledge and thank this Pennsylvania hospital for its transparency and disclosure of this event. It could have happened anywhere, and it has served as a “wake-up” call to many.

Tennessee has joined the effort.

As a result of the Pennsylvania Patient Safety Advisory reporting that the use of color-coded patient alert wristbands could, if not done uniformly, create unnecessary risk, many states began to work toward standardization in acute care hospitals.

In 2009, the Tennessee Hospital Association’s Tennessee Center for Patient Safety approved a statewide initiative to bring this patient safety effort to Tennessee. Tennessee joins nearly 30 states implementing standardized wristband colors for allergies, falls and do-not-resuscitate.

Standardizing the colors of alert wristbands across the state and the nation helps staff members do their jobs better and safer. Nurses and others no longer have to remember colors or symbols unique to a specific hospital. They can learn a single set of rules that will apply in most Tennessee hospitals.

- Red means allergy alert.
- Yellow means fall risk.
- Purple means do-not-resuscitate.

Color-Coded Wristband Standardization Project in Tennessee

Hospital Implementation Program

A guide for clinical and non-clinical staff
Educating patients and families is important. How something is said is just as important as what is said. It also is important to have a consistent message to help patients/families remember what is said and instill a sense of confidence in the healthcare system since all staff members deliver the same information.

The following model “script” should be used to deliver consistent information to patients and families about the standardized color-coded patient alert wristband program.

**Script**

**What is a color-coded patient alert wristband?**
Color-coded patient alert wristbands are used in hospitals to quickly communicate a certain healthcare status or condition that a patient may have. The color-coded wristband is a visual “alert” for all staff members, and helps every staff member provide the best care possible.

**What do the different colors mean?**
This hospital uses three different color-coded patient alert wristbands. They are commonly used in Tennessee, as well as in hospitals in multiple other states.

**Red means allergy alert.**
Patients should inform caregivers about an allergy to anything—food, medicine, latex, dust, grass, pet hair, etc. The red wristband reminds caregivers to check the allergy before delivering food, medicine or other aspects of care. This can be very important to avoid unpleasant or serious reactions.

**Yellow means a risk to falls.**
The hospital wants to prevent falls at all times. Nurses continuously assess patients to determine if they need extra attention to prevent a fall. Sometimes, a person may become weakened due to illness or because of a recent surgery. When a patient has this color-coded alert wristband, the nurse is indicating this patient needs to be assisted when walking to avoid a possible fall.

**Purple means the physician has written a do-not-resuscitate order.**
When patients have expressed an end-of-life wish, the hospital and its caregivers want to honor it.

**Risk-Reduction Strategies Staff Should Know**

**Color-Coded Patient Alert Wristbands/ Risk-Reduction Strategies Quick Reference Card**

1. Use wristbands with the alert message pre-printed (such as DNR).
2. Remove any “social cause” colored wristbands (such as LIVESTRONG).
3. Remove wristbands that have been applied by another facility, except for emergency identification bands.
4. Initiate banding upon admission, changes in condition or receipt of information during the hospital stay.
5. Educate patients and family members regarding the wristbands.
6. Coordinate chart/white board/care plan/door signage information/stickers with same color coding.
7. Educate staff to verify color-coded patient alert wristbands upon assessment and during hand-offs of care and facility transfer communication.
## Sample Staff Competency Checklist

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

### Methods Used to Evaluate Competency:

A. Demonstration  
B. Direct Observation/Checklist  
C. Video/PowerPoint® Review  
D. Skills Lab  
E. Self-Study and Test  
F. Data Management  
G. Other  

<table>
<thead>
<tr>
<th>Color-Coded Patient Alert Wristband Process</th>
<th>Date</th>
<th>Method Used</th>
<th>Evaluator’s Initials</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss what the three colors mean.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Describe processes related to the application, reapplication and removal of wristbands, including who is authorized to apply and remove them.</td>
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</tr>
<tr>
<td>Provide an explanation of the policy as it relates to “social cause” wristbands.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe process used to educate patients and families about the color-coded wristbands.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe process used when patient refuses to participate in hospital policy related to use of color-coded alert wristbands.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe communication processes among staff at time of patient handoffs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review patient instructions and staff responsibilities related to wristbands at the time of hospital discharge.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Evaluator’s initials signify competency was achieved

---

| Employee Name: | | |
| Evaluator Name and Initials: | | |
| Evaluator Job Title: | | |

---

Employee Signature  
Date

---

Evaluator Signature  
Date
Patient Education
The Tennessee Hospital Association, Tennessee Center for Patient Safety and Tennessee hospitals are undertaking an effort voluntary to improve patient safety by adopting standard wristband colors.

Standardizing the colors of alert wristbands across the state— and the nation— helps staff members do their jobs better and safer.

Nurses and others no longer have to remember colors or symbols unique to a specific hospital. This is a simple, effective way to reduce errors and improve patient outcomes.

Understanding the Color-Coded Patient Alert Wristband Standardization Project in Tennessee
Why a color-coded patient alert wristband?
Color-coded patient alert wristbands are used in hospitals to quickly communicate a certain healthcare status or condition that a patient may have. The color-coded wristband is a visual “alert” for all staff members, and helps them provide the best care possible. In addition to the meaning associated with the specific color, the alert is written on the alert wristband to reduce the chance of confusion.

Statewide Patient Safety Initiative
To improve patient safety in the delivery of health care is a goal for this and every hospital. One of the many ways this hospital works to prevent potential errors is the use of standardized color-coded patient wristbands to alert staff members to specific conditions or a special status. This is a voluntary initiative in Tennessee and the same colors for three specific alerts are used in more than 30 other states.

What do the different colors mean?
This hospital uses three different color-coded patient alert wristbands, and they are commonly used in Tennessee, as well as in hospitals in other states.

Red means allergy alert.
An allergy to anything—food, medicine, latex, dust, grass, pet hair, etc.—should be documented. The red wristband reminds caregivers to check the allergy before delivering food, medicine or other aspects of care. This can be very important to avoid unpleasant or serious reactions.

Yellow means a risk to falls.
Nurses continuously assess patients to determine if they need extra attention to prevent a fall. Sometimes, a person may become weakened due to illness or because of a recent surgery. When a patient has this color-coded alert wristband, it is indicated that this patient needs to be assisted when walking to avoid a possible fall.

Purple means the physician has written a do-not-resuscitate order.
When patients have expressed an end-of-life wish, the hospital and its caregivers want to honor it.

Patients and family members need to be involved.
By knowing the meaning of the colored wristbands, you can help your caregivers meet your needs.

Please share information about allergies with your caregivers. This includes foods and pollens, as well as medication allergies.

If you have a tendency to lose your balance, tell your nurse. If you feel faint or unsteady after a procedure or following sedation, inform your caregiver and do not try to get up without assistance.

If you have an advance directive, please tell your team of caregivers. An advance directive tells your doctor what kind of care you want, if you become unable to make medical decisions. If you want to complete an advance directive, talk to your nurse. This hospital wants to honor your wishes and documenting your preferences allows us to do so.

Patients and family members need to be involved.
Community Education

Organizations that decide to voluntarily standardize color-coded patient alert wristbands should ensure that other stakeholders and healthcare providers with whom they have relationships are made aware of the hospital's involvement in this effort. The following list includes organizations that the hospital should alert about the wristband standardization effort:

- Local charitable organizations, particularly those that use and distribute “social cause” wristbands
- Local print and television media
- Local ambulance services
- Local nursing homes
- Local medical societies
- Dialysis centers
- Imaging centers
- Wound centers
- Ambulatory surgical facilities
- Home health services
- Hospice providers
- Radiation oncology centers
- Staffing agencies
- Local physician offices
- Affiliated education organizations
- Services for which the hospital contracts
Sample Information Letter: Social Cause and Charity Groups

<<Date>>

<<Recipient>>
<<Organization>>
<<Street Address>>
<<City>><<State>>, <<ZIP>>

Dear:

Hospitals in Tennessee and across the country are supporting a voluntary effort to standardize the meanings of color-coded patient alert wristbands used in hospitals in order to improve caregiver recognition and communication and reduce the risk of error by having different meanings attached to different colors in different hospitals. As part of this overall effort, we are discouraging patients from wearing social cause wristbands when hospitalized.

Social cause wristbands often are intended to bring positive awareness to special interests or social movements, such as fighting cancer or other diseases, and in some cases, they are worn as a fashion statement. However, hospitals often use color-coded wristbands to provide visual cues about a patient's clinical status or medical condition. This means there is a greater potential for mistakes or errors to occur if hospital staff inadvertently mistake one of the social cause wristbands for one that imparts important clinical information or directives. For instance, a social cause purple wristband is worn to bring awareness to Alzheimer's disease, but a purple alert wristband used in the hospital means that the patient has indicated that he/she does not want to be resuscitated. If a person wearing a purple social cause wristband was to experience a cardiac arrest while hospitalized, hospital staff could mistakenly interpret the wristband to mean the patient does not want to be resuscitated.

We are encouraging charities, foundations and fundraising groups to consider this information when planning their next events. There are no restrictions or risks associated with the use of lapel pins, ribbons or beaded bracelets and would suggest these options as suitable alternatives in the future.

Thank you in advance for your consideration and support in this important patient safety initiative. Should you have any questions or concerns, please contact (include appropriate hospital contact)

Respectfully,

<<Name>>
<<Title>>
<<Hospital Name>>
<<Contact Information>>
**Sample Information Letter: Other Community Healthcare Providers**

<<Date>>

<<Recipient>>
<<Organization>>
<<Street Address>>
<<City>>, <<State>>, <<ZIP>>

Dear:

Hospitals in Tennessee and across the country are supporting a voluntary effort to standardize the meanings of color-coded patient alert wristbands used in hospitals and other healthcare facilities in order to improve caregiver recognition and communication and reduce the risk of error by having different meanings attached to different colors in different hospitals. As part of this overall effort, we are discouraging patients from wearing social cause wristbands when hospitalized.

Social cause wristbands are often intended to bring positive awareness to special interests or social movements such as fighting cancer or other diseases, and in some cases, they are worn as a fashion statement. However, hospitals often use color-coded wristbands to provide visual cues about a patient's clinical status or medical condition. This means there is a greater potential for mistakes or errors to occur if hospital staff inadvertently mistake one of the social cause wristbands for one that imparts important clinical information or directives. For instance, a social cause purple wristband is worn to bring awareness to Alzheimer's disease, but a purple alert wristband used in the hospital means that the patient has indicated that he/she does not want to be resuscitated. If a person wearing a purple social cause wristband was to experience a cardiac arrest while hospitalized, hospital staff could mistakenly interpret the wristband to mean the patient does not want to be resuscitated.

As of (Include Date Here), our hospital will be officially using three standard colors for patient alert wristbands to signify three specific medical conditions. Since you may be treating patients that may have been hospitalized at (Name of Hospital), we want to make sure you know the significance of each color. In addition, we want to inform you that the established practice is to leave these color-coded patient alert wristbands in place at the time of discharge. If you are providing post-acute care services, you may encounter patients with these wristbands in place which communicate important clinical information. The chart below presents the meaning of each color-coded patient alert wristband:
<table>
<thead>
<tr>
<th>Wristband 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>Purple</td>
<td>DNR</td>
</tr>
</tbody>
</table>

We encourage you to alert your staff to the meaning of each color. As appropriate, you also might consider using these exact colors to indicate their respective risks in your facility. For more information about this initiative, visit the Tennessee Hospital Association web site at [www.tha.com](http://www.tha.com).

Thank you in advance for your consideration and support in this important patient safety initiative. Should you have any questions or concerns, please contact (include appropriate hospital contact).

Respectfully,

<<Name>>
<<Title>>
<<Hospital Name>>
<<Contact Information>>
Sample News Release/Newsletter Article
The following news release for distribution to local media outlets can be adapted for employee newsletters, or volunteer and community publications.

<<Place on Hospital/Health System Letterhead>>

<<EMBARGOED UNTIL THE THA PUBLIC RELEASE Scheduled for September 2009>>

FOR IMMEDIATE RELEASE
Date (to be determined)  
Contact: NAME, TITLE
PHONE
CITY, Tennessee—HOSPITAL/HEALTH SYSTEM NAME has announced a plan to standardize the use of color-coded patient alert wristbands in a statewide initiative focused on reducing inconsistencies between Tennessee hospitals that can result in medical errors. The goal of the effort is to decrease the risk of such errors by standardizing the colors of three patient alert wristbands: allergy (red), fall risk (yellow) and do-not-resuscitate (purple) by Dec. 31, 2009.

“At HOSPITAL/HEALTH SYSTEM NAME, our number one priority is ensuring high quality health care for all of our patients,” said FIRST LAST NAME, TITLE. “By agreeing to join a majority of hospitals in using the same color wristbands, it improves the patients’ experiences, regardless of which facilities provide the patient care and throughout the duration of a patient’s treatment. This is one simple, but important, step to help ensure safe, quality care.”

As of summer 2009, more than 30 states had standardized color-coded patient alert wristbands. Consistent with these states, the Tennessee Hospital Association’s (THA) Tennessee Center for Patient Safety is leading a similar effort to consistently and effectively communicate an alert to a healthcare provider if the patient has an allergy, is a fall risk and/or carries a do-not-resuscitate (DNR) order. In addition to the meaning associated with the specific color, the alert is preprinted on the wristband to further reduce the chance for confusion when patients, physicians and nurses travel between different hospitals.

THA clarified that this initiative is not meant to encourage hospitals to begin using color-coded patient alert wristbands if a facility currently does not use wristbands. Rather, the initiative’s goal is to gain a 100 percent standardization rate among those Tennessee hospitals that currently use color-coded patient alert wristbands.

In order for the color-coded patient alert wristband initiative to be truly successful, patients and family members need to understand the meaning behind the wristband colors, hospitals officials say.
“If patients have allergies to foods, pollens or medications, they should share that information when admitted,” LAST NAME said. “If they have a tendency to lose their balance, they should tell their nurse or physician. And if they have an advance directive, they should let their caregivers know so that their wishes can be honored. Lastly, patients should leave any “social cause” (i.e. Lance Armstrong’s “LIVESTRONG” yellow bracelet) wristbands at home to avoid confusion.”

For more information about HOSPITAL/HEALTH SYSTEM NAMES standardized wristband initiative, please contact CONTACT NAME/INFO # # #
Information for Vendor Supplies

It is important that the colors of the patient alert wristbands used between Tennessee hospitals remain uniform; therefore, provide your alert wristband vendor with the specifications listed below. You may use any vendor you wish.

<table>
<thead>
<tr>
<th>Wristband Type</th>
<th>Color Specifications</th>
<th>Text Specifications</th>
<th>Font Style &amp; Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Wristband</td>
<td>Red PMS 1788</td>
<td>&quot;ALLERGY&quot; in Black</td>
<td>Arial Bold, 48 pt All Caps</td>
</tr>
<tr>
<td>Fall Risk Wristband</td>
<td>Yellow PMS 102</td>
<td>&quot;FALL RISK&quot; in Black</td>
<td>Arial Bold, 48 pt All Caps</td>
</tr>
<tr>
<td>DNR Wristband</td>
<td>Purple PMS 254</td>
<td>&quot;DNR&quot; in White</td>
<td>Arial Bold, 48 pt All Caps</td>
</tr>
</tbody>
</table>
Acknowledgements

In concert with the leadership of THA and the Tennessee Center for Patient Safety, Tennessee hospitals are undertaking a voluntary effort to improve patient safety. These organizations are pleased to share the contents of this work product with any organization.

Wristband standardization materials can be accessed at www.tha.com or www.tnpatientsafety.com. To obtain additional information about this project, contact: Chris Clarke, THA senior vice president, clinical & professional practices, cclarke@tha.com, or Darlene Swart, TCPS director, dswart@tha.com.

THA appreciates the leadership of the THA Quality Committee for its input and guidance on this important patient safety initiative.

Contributors

THA also expresses special appreciation to:

- The Michigan Health and Hospital Association for allowing use and adaptation of its toolkit and resources for Tennessee.
- The Arizona Hospital and Healthcare Association for allowing use and modification of its intellectual property on which this toolkit is based.
- The Hospital & Healthsystem Association of Pennsylvania and Texas Hospital Association for allowing use and modification of its intellectual property on which this toolkit is based.
- The Pennsylvania Color of Safety Task Force, a group of 13 hospitals in northeast and central Pennsylvania that came together to standardize color-coded patient alert wristbands on a regional level. This task force created the original implementation toolkit and served as the catalyst behind other similar state initiatives.