



Risk Reduction Strategies

Color-coded “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 “Live Strong”).
3. Remove wristbands that have been applied from another facility.
4. Initiate banding upon admission, changes in condition, or when information is received 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 patient color-coded “alert” wristbands upon assessment, hand-off of care, and facility-to-facility transfer communication.

The following information takes each risk reduction strategy and provides further detail and/or explanation of that strategy.

1. **Use wristbands that are pre-printed with text that tells what the band means.**
 - a. This can reinforce the color-coding system for new clinicians, help caregivers interpret the meaning of the band in dim light, and also help those who may be color-blind.
 - b. Eliminates the chance of confusing colors with alert messages.
2. **Remove any “social cause” (such as Live Strong, Cancer, etc.) colored wristbands.**
 - a. Be sure this is addressed in your hospital policy.
 - b. If that can’t be done, you can cover the band with a bandage or medical tape, but removal altogether is best.
3. **Remove wristbands that have been applied from another facility.**
 - a. This should be done when patients are processed to enter the facility and/or during patient admission.
4. **Initiate banding upon admission, changes in condition, or when information is received during the hospital stay.**
5. **Educate patients and family members regarding the purpose and meaning of the wristbands.**
 - a. Including the patient and family safeguards the hospital, healthcare professionals, and patient from potential errors.
 - b. Remind patients and families that color-coding provides another opportunity to prevent errors.
 - c. Use the patient/family education brochure located in the tool kit.
6. **Coordinate chart/white board/care plan/door signage information/stickers with the same color-coding – red for allergies, yellow for fall risk, and purple for DNR status.**
7. **Educate staff to verify patient color-coded “alert” wristbands upon assessment, hand-off of care, and facility-to-facility transfer communication.**

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8. When possible, limit the use of colored wristbands for other categories of care, e.g. MRSA, special needs, etc.
9. Remember, the wristband is a tool to communicate an alert status.
 - a. Educate staff to utilize the patient medical record information (physician order for DNR) as an additional resource for verification processes for allergies, fall risk, and advance directives.
10. If your facility uses pediatric wristbands that correspond to the Broselow color-coding system for pediatric resuscitation, take steps to reduce any confusion between these Broselow colors and the colors on the wristbands used elsewhere in the facility.

To improve patient safety in the delivery of healthcare has become a goal for every organization. A part of that is to reduce risks for injury or harm whenever possible. By implementing risk reduction strategies, we demonstrate patient safety in a consistent fashion.

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

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

Communication is a leading, contributing factor for 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 between other healthcare facilities.

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