

# Color-coded Wristband Standardization in Iowa



“Patient safety is sound clinical practice”

Color-coded Wristband  
Standardization in Iowa  
**Case for Change**



## **Background:**

- **In 2005 in Pennsylvania there was confusion regarding wristband color that resulted in a patient being labeled DNR erroneously. As a result they took the lead in standardizing colored wristbands.**
- **In 2008 the Iowa Healthcare Collaborative collected baseline data after concern was voiced about wristband variation in Iowa hospitals**

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- In the state of Iowa, it was discovered that around 73% of Iowa hospitals use colored wristbands to increase awareness of certain patient risks. However, the color and usage process varied tremendously from hospital to hospital. Results of a survey conducted by IHC are as follows:**

**REPORTED COLORS USED BY IOWA HOSPITALS 2008**

Condition / Percent Reporting	Red	Yellow	Blue	Pink	Purple	Orange	White	Green	Other	None
Allergy / 68%	56.6%	3.9%	0.0%	0.0%	0.0%	1.3%	0.0%	0.0%	3.9%	34.2%
Fall Risk / 67%	0.0%	21.1%	2.6%	1.3%	6.6%	3.9%	0.0%	3.9%	6.6%	53.9%
Do Not Resuscitate / 67%	0.0%	2.6%	18.4%	0.0%	7.9%	0.0%	2.6%	3.9%	3.9%	60.5%
Latex Allergy / 50%	10.5%	1.3%	3.9%	0.0%	1.3%	0.0%	0.0%	3.9%	2.6%	76.3%
Restricted Extremity / 41%	0.0%	0.0%	0.0%	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	97.4%
Blood Products / 43%	9.2%	5.3%	0.0%	0.0%	0.0%	0.0%	2.6%	2.6%	2.6%	77.6%

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### What does this mean?

- **Potential for confusion exists**
- **Opportunity to reduce potential for harm and improve patient safety**

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## What did we do?

- **Reviewed current standardization models in use**
- **Discussion and “Building the Will” for change**
- **Consensus to standardize three condition alerts**
  - **Allergy**
  - **Fall Risk**
  - **Do Not Resuscitate**

*• Alone we can do so little; together we can do so much.*

*~ Helen Keller*

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## **Arizona model**

- **Multidisciplinary work group formed through the Arizona Hospital and Healthcare Association**
- **Task:**
  - ✓ **Reach consensus on color definitions**
  - ✓ **Develop work plan and implementation Tool Kit**

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**The Tool Kit contents include:**

- 1. The colors for the alert designation**
- 2. The logic for the colors selected**
- 3. A work-plan for implementation**
- 4. Staff education including competencies**

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### The Tool Kit contents include (cont.):

5. Patient education brochure
6. FAQs for general distribution
7. Sample policy and procedure
8. Vendor information for easy adoption

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**Our safety as a state and success in this effort will depend on the participation and adoption of each Iowa hospital using alert wristbands.**

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## Color-coded Wristband Standardization in Iowa



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**Allergy**



***Recommendation: RED for Allergy***

**It is recommended that hospitals adopt the color RED for the ALLERGY ALERT designation with the words embossed/printed on the wristband, clasp or label, “ALLERGY.”**

**Quick Adoption**

*By adopting red for allergy alert, the standardization for this is easily achieved since 56% of IA hospitals reporting already use red for allergy alert.*



## ***Recommendation - RED for Allergy Alert***

### **1. Why Red?**

- **56% of Iowa hospitals reporting currently use red**

### **2. Any other reasons?**

- **Associated with other messages such as STOP! DANGER! due to traffic lights and ambulance/police lights.**

### **3. Do we write the allergies on the wristband too?**

- **No because that may create new errors due to:**
  - **Legibility issues**
  - **Allergy list may change**
  - **Patient chart should be the source for the specifics**

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**Fall Risk**



***Recommendation: YELLOW for Fall Risk***

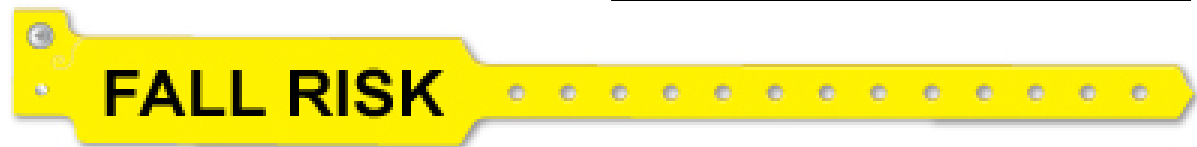
**It is recommended that hospitals adopt the color YELLOW for the Fall Risk Alert designation with the words embossed/written on the wristband, clasp or label, “Fall Risk.”**



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



FALL RISK



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## ***Recommendation - YELLOW for Fall Risk***

### **1. Why Yellow?**

- **Associated with “Caution” or “Slow Down”  
(Stop Lights and School Buses)**
- **American National Standards Institute (ANSI)**
- **All health care providers want to be alert to fall risks as they can be prevented.**

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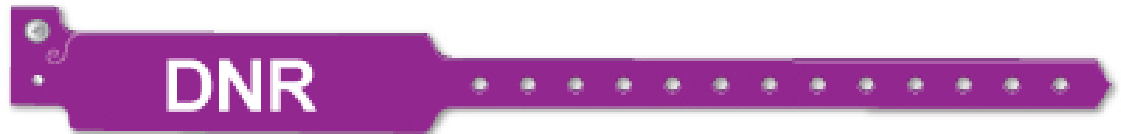
## Do Not Resuscitate

### *Recommendation: PURPLE for Do Not Resuscitate*

It is recommended that hospitals  
adopt the color **PURPLE** for the  
**Do Not Resuscitate** designation  
with the words embossed/printed  
on the wristband, clasp or label,  
“DNR.”

### Calling CODE BLUE!

- *Is used by the vast majority to call a code.*
- *If Iowa selected the color blue for the DNR wristband, the potential for confusion exists.*
- *“Does blue mean I code or I do not code?”*



## Do Not Resuscitate



### *Recommendation - PURPLE for Do Not Resuscitate*

1. **Why not blue?**
  - **Should not be the same color that is used for calling a code**
  - **Registry, turnover, travelers, etc.**
2. **Why not green?**
  - **Color-blind**
  - **“Go ahead” confusion**
3. **If we adopt purple, do we still need to look in the chart?**
  - **Yes!**
  - **Code designation can and does change during a patients stay**

## Color-coded Wristband Standardization in Iowa



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**A suggested Work Plan for Facility Preparation,  
Staff Education, and Patient Education  
that includes:**

- 1. Organizational Approval**
- 2. Supplies Assessment and Purchase**
- 3. Hospital Specific Documentation**
- 4. Staff and Patient Education Materials and Training**

**Following the Work Plan is a Task Chart for each plan that provides cues for methodical and successful implementation.**

# Color-coded Wristband Standardization in Iowa Sample Work Plan Document



**Color-coded Wristband Standardization in Iowa**

**Suggested Work Plan for Facility Preparation, Staff Education, and Patient Education**

**Area #1**  
Organizational Approval  
*See Task Chart for specific steps*

**Review**

✓ Adapting this initiative may require approval by appropriate committees, such as:

- Patient Safety Committee
- Medical Staff Committee
- Quality Improvement Council
- Board of Directors

**Action Plan**

Organizations have different committees that are required to approve systemwide changes, or changes that directly impact patients. Each organization needs to assess which committees need to approve the adoption of the initial set and begin to get on meeting agendas for approval. For some organizations, this may mean simply a presentation at one committee, such as the Patient Safety Committee. Other organizations may need to have this approved by several committees, depending on their culture.

Consider the stakeholders and be sure they understand the initiative before it is planned so they can support it.

**Area #2**  
Supplies Assessment and Purchase  
*See Task Chart for specific steps*

**Review**

✓ Assessment of current supply    ✓ Wristband procurement

**Action Plan**

Most organizations have a vendor they use for wristbands. It is important to communicate to your vendor that you are adopting the A1 color model for color-coded wristbands. Most vendors are aware of the initials and what bands should be ordered. However, if yours does not know, inform it of the colors and the start message that needs to be printed clearly on the band. Please see "Vendor Information" section. Vendors do need some lead time for the printing (about 2-3 weeks).

Coordinate with your Materials Management Department to evaluate when current stock will be used up. Once this is known, the rest of the implementation plan will "lock in" into this date.

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## Color-coded Wristband Standardization in Iowa



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## **Color-coded Wristband Standardization in Iowa Policies & Procedures**



- **A template Policies & Procedures has been provided.**
- **Make modifications to it so it fits your organization’s process and culture.**
- **Includes a “Patient Refusal to Participate in the Wristband Process” process.**

# Color-coded Wristband Standardization in Iowa Excerpt from Refusal Form



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

- Wear color coded alert wristbands.

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

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

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

Reason provided (if any): \_\_\_\_\_

Date / Time

\_\_\_\_\_  
Signature / Relationship

\_\_\_\_\_  
Date / Time

\_\_\_\_\_  
Witness Signature / Job Title

## Color-coded Wristband Standardization in Iowa



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## **Color-coded Wristband Standardization in Iowa Staff Education**



### **Tools for Staff Education:**

- **Poster announcing the training meeting dates/times**
- **Staff Sign-In Sheet**
- **Staff competency check list**
- **Tri-fold Staff education brochure about this initiative**
- **FAQs hand out for staff**
- **Tri-fold Patient education brochure about color coded wristbands**
- **PowerPoint presentation**

## **Tri-fold Staff education brochure that includes:**

- 1. How this all got started...The Pennsylvania story**
- 2. Why we need to do this in Iowa**
- 3. The National picture**
- 4. What the colors are for Allergy, Fall Risk and DNR**
- 5. Script for any staff person talking to a patient or family about the wristbands**
- 6. “Quick Reference Card” cut out that lists 7 other risk reduction strategies**

**Color Coded “Alert” Wristbands / Risk Reduction  
Strategies A Quick Reference Card**

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- 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.**

**Color Coded “Alert” Wristbands / Risk Reduction Strategies  
A Quick Reference Card**

=====

- 4. Initiate banding upon admission, changes in condition, or when information is received during 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” arm bands upon assessment, hand- off of care and facility transfer communication.**

## **Why have a Script for Staff?**

- 1. We know *how* we say something is as important as *what* we say. This provides a script sheet so staff can work on the “how” as well as the “what.”**
- 2. Serves as an aid to help staff be comfortable when discussing the topic of a DNR wristband.**
- 3. Promotes patient/family involvement and reminds the patient/family to alert staff if information is not correct.**
- 4. By following a script, patients and families receive consistent message – which helps with retention of the information.**
- 5. Patient Education brochure also available for staff to hand out.**

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**Staff Education**



***SCRIPT for any staff person talking to a patient or family***

***What is a Color Coded “Alert” Wristband?***

*Color coded alert wristbands are used in hospitals to quickly communicate a certain health care status, condition, or an “alert” that a patient may have. This is done so every staff member can provide the best care possible.*

***What do the colors mean?***

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

***~ continued on next slide~***

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Standardization in Iowa  
**Staff Education**



***SCRIPT for any staff person talking to a patient or family***

***RED means ALLERGY ALERT***

*If a patient has an allergy to anything - food, medicine, dust, grass, pet hair, ANYTHING- tell us. It may not seem important to you but it could be very important in the care the patient receives.*

***YELLOW means FALL RISK***

*We want to prevent falls at all times. Nurses assess patients all the time to determine if they need extra attention in order to prevent a fall. Sometimes, a person may become weakened during their illness or because they just had a surgery. When a patient has this color coded alert wristband, the nurse is indicating this person needs to be closely monitored because they could fall.*

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Color-coded Wristband  
Standardization in Iowa  
**Staff Education**



***SCRIPT for any staff person talking to a patient or family***

***PURPLE means “DNR” Or Do Not Resuscitate***

*Some patients have expressed an end-of-life wish and we want to honor that.*

## Color-coded Wristband Standardization in Iowa



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## Color-coded Wristband Standardization in Iowa Resources



**Questions? Contact Gail Meyer at:  
(515) 283-9322 or  
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- **You may access the online information at [www.ihconline.org](http://www.ihconline.org).  
Click on the “Tool Kit” header at the top of the page.  
Select Wristband Tool Kit. Find the file that contains the document  
you need.**