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

“Patient safety is sound clinical practice”
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:

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

“There is a survey conducted by IHC,” page 3

“Patient safety is sound clinical practice”
What does this mean?

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

“Patient safety is sound clinical practice”
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

\[ \textit{Alone we can do so little; together we can do so much.} \]
\[ \sim \text{Helen Keller} \]
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

“Patient safety is sound clinical practice”
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
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

“Patient safety is sound clinical practice”
Our safety as a state and success in this effort will depend on the participation and adoption of each Iowa hospital using alert wristbands.

“Our safety is sound clinical practice”
“Patient safety is sound clinical practice”
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.

“Patient safety is sound clinical practice”
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

“Patient safety is sound clinical practice”
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.”

“Patient safety is sound clinical practice”
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.

“Patient safety is sound clinical practice”
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?”

“Patient safety is sound clinical practice”
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

“Patient safety is sound clinical practice”
Color-coded Wristband Standardization in Iowa

“IHC
Iowa Healthcare Collaborative
A Partnership for Quality, Patient Safety & Value

Planning and Implementation

“Patient safety is sound clinical practice”
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.

“Patient safety is sound clinical practice”
“Patient safety is sound clinical practice”
"Patient safety is sound clinical practice"
Color-coded Wristband Standardization in Iowa

"Patient safety is sound clinical practice"
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.
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

“Patient safety is sound clinical practice”
“Patient safety is sound clinical practice”
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

“Patient safety is sound clinical practice”
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

“Patient safety is sound clinical practice”
Color Coded “Alert” Wristbands / Risk Reduction Strategies A 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.

“Patient safety is sound clinical practice”
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.

“Patient safety is sound clinical practice”
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.

“Patient safety is sound clinical practice”
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 ~
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.

~ continued on next slide~
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.

“Patient safety is sound clinical practice”
Color-coded Wristband Standardization in Iowa

"Patient safety is sound clinical practice"
Questions? Contact Gail Meyer at:
(515) 283-9322 or
meyerg@ihconline.org

• You may access the online information at 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.