Oklahoma Hospital Association

Implementation Tool Kit

Sponsored by:

THE St. John COMPANIES

"Banding Together for Patient Safety"

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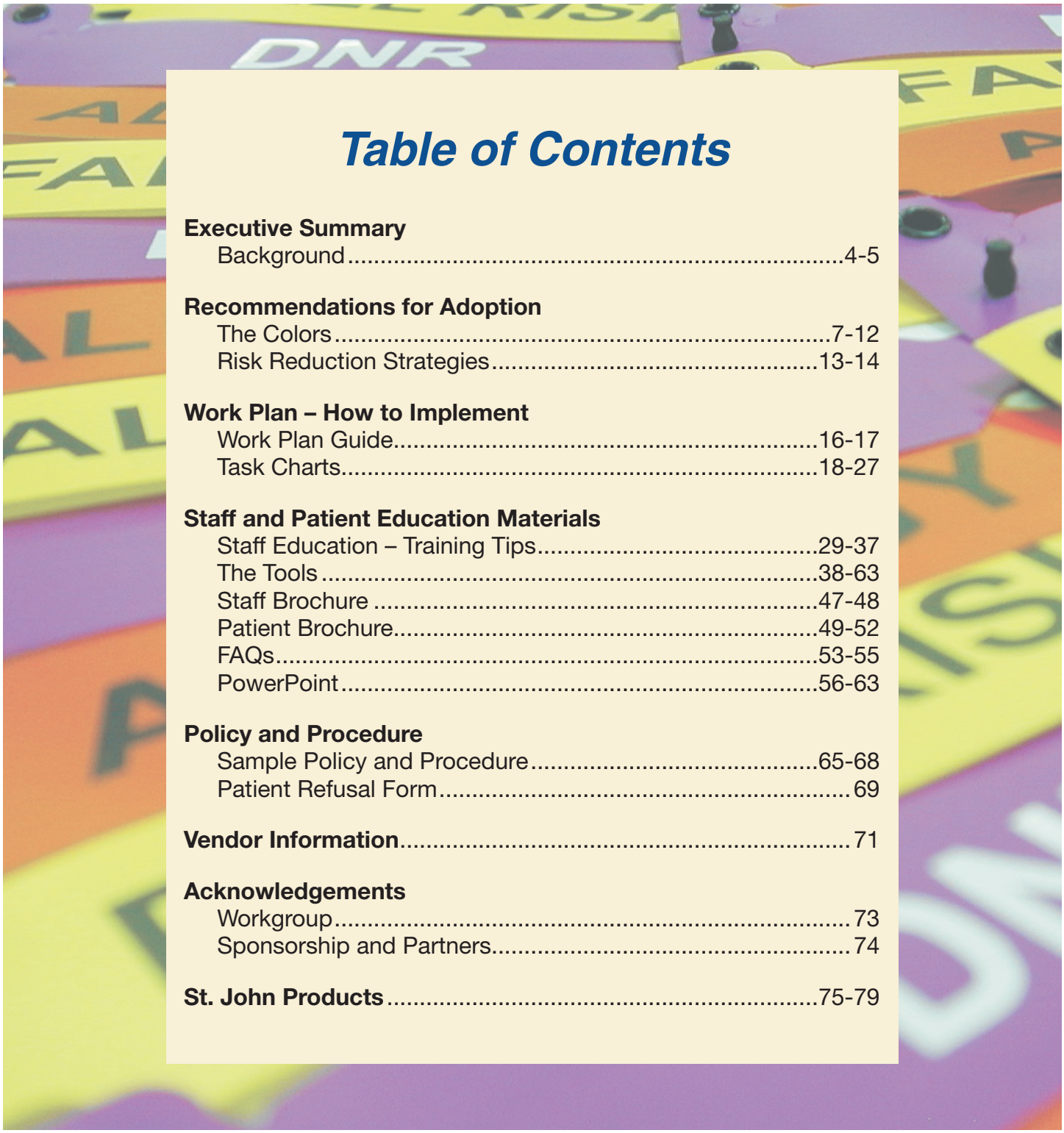
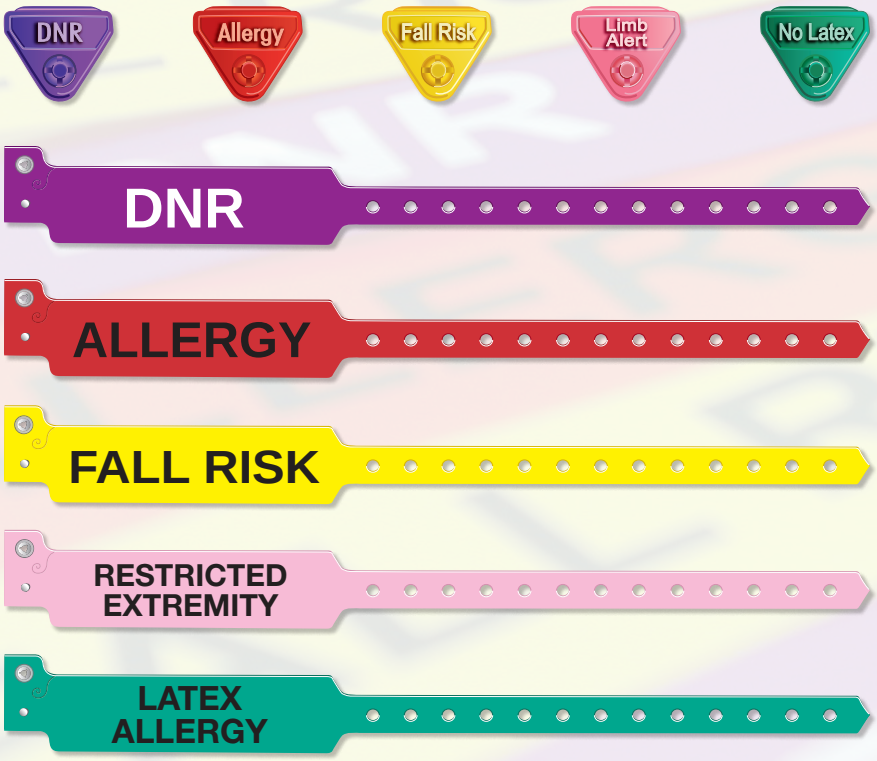


Table of Contents

Executive Summary



Executive Summary — May 2009

In December 2005, a patient safety advisory was issued from the Pennsylvania Patient Safety Reporting System that received national attention. This advisory brought to surface an incident that occurred in a hospital in which clinicians nearly failed to rescue a patient who had a cardiopulmonary arrest because the patient had been incorrectly designated as "DNR" (Do Not Resuscitate).

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

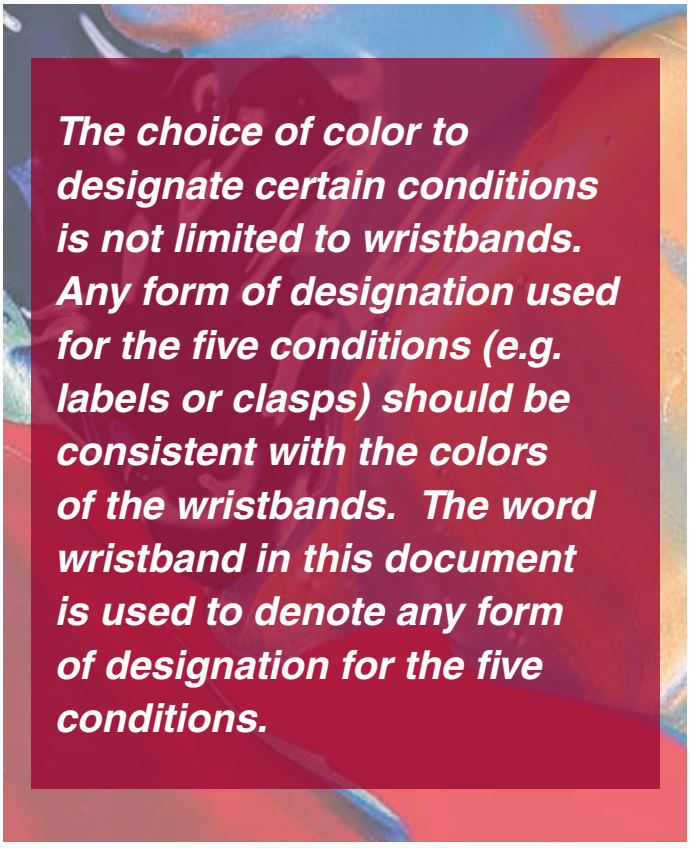
Most of us can imagine this type of near miss occurring in any institution. Consider these statistics regarding hospital staff:

- Nursing shortage/vacancies: in 2008, the Oklahoma Health Care Workforce Center cited that there were 1,662 nursing vacancies in Oklahoma hospitals.
- The nursing turnover rate is 17.5%.
- Hospitals are using agency and traveling nurses to staff vacant positions.

The potential for confusion is obvious, significant and avoidable.

In Oklahoma, many facilities use color-coded patient wristbands to alert caregivers to certain patient risks. However, because hospitals use different colors for these alerts, caregivers working in more than one facility may have difficulty always responding in the appropriate manner. Identification of these patients must be clear, consistent and well communicated.

The American Hospital Association (AHA) has issued a quality advisory recommending that hospitals consider using certain standardized colors for alert wristbands. Currently, the majority of states have adopted three standardized colors for alert wristbands, although some use more. The three main standard colors, which have been adopted as a consensus in numerous states, are: red for patient allergies; yellow for a fall risk; and purple for do-not-resuscitate patient preferences. Several states have also adopted green for latex allergy and pink for restricted extremity. Standardizing the colors of the wristbands used in hospitals is the sensible approach to improving patient safety.



The choice of color to designate certain conditions is not limited to wristbands. Any form of designation used for the five conditions (e.g. labels or clasps) should be consistent with the colors of the wristbands. The word wristband in this document is used to denote any form of designation for the five conditions.

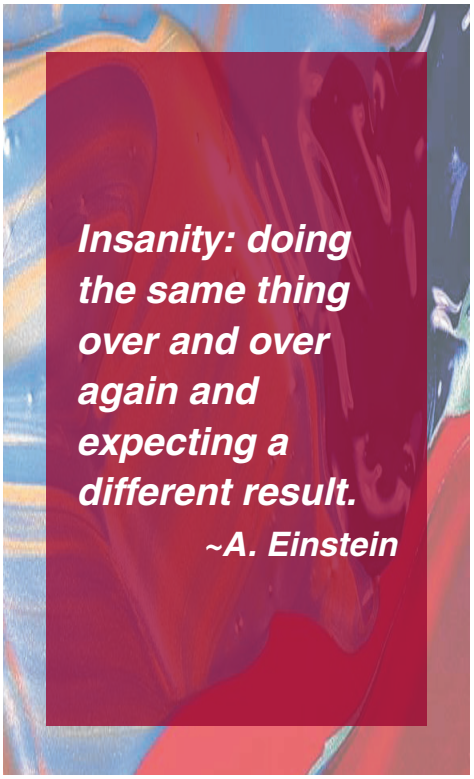
Executive Summary continued

In early 2009, both the Greater Oklahoma City Hospital Council and the Tulsa Hospital Council approved the recommendations to accept the three American Hospital Association's recommended wristband alert colors (red for patient allergies, yellow for a fall risk and purple for do-not-resuscitate patient preferences) for standardization within the two metro areas. They also recommend that hospitals adopt green for latex allergies and pink for restricted extremity use.

The Oklahoma Hospital Association Council on Quality and Patient Safety accepted the recommendations from the hospital councils and the OHA Board of Directors approved a statewide initiative supporting these five colors for standardization.

The information that follows in this kit will guide your organization through:

1. The colors for the alert designation and logic for the colors selected.
2. Work plan for implementation.
3. Staff education including competencies.
4. FAQs for general distribution.
5. Sample policy and procedure.
6. Vendor information for easy adoption of the recommendation.
7. Patient education brochure.



Our safety as a state and success in this effort will depend on the participation and adoption of each and every hospital in this state. This effort will require a willingness to change for the greater good. Some hospitals will have a minor change while others may have a major change. We realize that change is difficult; we also realize that change made for reasons that benefit the safety of your staff, your loved ones and your communities are changes for all the right reasons.


DNR
ALLERGY
FALL RISK
Recommendations for Adoption
DNR
Allergy
Fall Risk
Limb Alert
No Latex
DNR
ALLERGY
FALL RISK
RESTRICTED EXTREMITY
LATEX ALLERGY

Recommendations for Adoption

Do Not Resuscitate

Recommendation:

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

While there is much discussion regarding the issue of "to band or not to band," a literature review to date has not identified a better intervention conclusively. One may say, "In the good old days, we just looked at the chart and didn't band patients at all." However, those days consisted of a workforce base that was largely employed by the hospital. Because an increasing number of health care providers working in hospitals are not hospital based staff, it is imperative that current processes take this into consideration. Registry and traveler staff may not be familiar with how to access information (as in the use of computerized charts) and may not be familiar with where to find information in the medical record, or even where to find the medical record. When seconds count, as in a code situation, we believe having an alert wristband on the patient will serve as a great tool. Similar to a second identifier, it will serve as a ready communication in a crisis situation, an evacuation situation, or in a transit situation.

FAQs

Q. **We don't use wristbands for DNRs at this hospital. Why should we consider adopting this?**

A. Wristbands are used in many Oklahoma hospitals to communicate an alert. Registry staff, travelers, non-clinical staff, etc. may be unaware of where to look in the medical record if they are new to your hospital. By having a wristband on, a quick warning is communicated so anyone could know about this alert. Additionally, it is also a means to communicate to the family that we are clear about their end-of-life wishes. By not having a band on, errors of omission could potentially be created.

Q. Why not use Blue?

A. The work group considered the work in Arizona, and the over 30 other states that have subsequently adopted purple to standardize DNR, and the rationale behind their decisions. It also took into consideration that a majority of Oklahoma hospitals call a code by announcing "Code Blue." By also having a blue DNR wristband and a "code blue" call, there was the potential to create confusion. Clinicians might ask, "Does blue mean we code or do not code?" To avoid creating any second-guessing in this situation, the decision was made to adopt the same guideline as in the majority of states — purple to designate DNR.

Q. Why not Green?

A. Again, we considered this color as well; however, due to color-blindness concerns, we decided to avoid it altogether. Also, in other settings the color green often has a "Go Ahead" connotation, such as traffic lights. We again want to avoid any possibility of sending "mixed messages" in a critical moment.

Q. So, if we adopt the purple DNR wristband then do we still need to look in the chart?

A. Yes. Some hospitals do not use wristbands for DNRs because they want the chart to be reviewed first for the most current code designation. However, that practice should be the practice in all cases – whether a wristband is being used or not. Code status can change throughout a hospitalization. It is important to know the current status so the patient's and family's wishes can be honored.

Calling Code Blue

In Arizona, 75 percent of hospitals used this term to call a code team. In talking with Oklahoma hospitals, we know many of them use this same term.

So, if Arizona had selected the color blue for the DNR wristband, the potential for confusion would exist.

"Does blue mean I code or I do not code?"

Recommendations for Adoption

Allergy Alert

Recommendation:

It is recommended that hospitals adopt the color RED for the Allergy Alert designation with the letters "Allergy" embossed/printed on the wristband, clasp or label.

FAQs

Q. **Why did you select red?**

A. Red was selected based on the fact that many hospitals currently use red to denote allergies. Even though some hospitals use red with blood typing, there were an equal number using it for allergies, and it seemed to have the connotation of stopping before proceeding.

Q. **Are there any other reasons for using red?**

A. Yes there are. Our research of other industries tells us that red has an association that implies extreme concern. The American National Standards Institute (ANSI) has designated certain colors with very specific warnings. ANSI uses red to communicate "Stop!" or "Danger!" We think that message should hold true for communicating an allergy status. When a caregiver sees a red allergy alert wristband they are prompted to "STOP!" and double check if the patient is allergic to the medication, food, or treatment they are about to receive.

Q. **Do we write the allergies on the wristband too?**

A. It is our recommendation that allergies be written in the medical record according to your hospital's policy and procedure. We suggest allergies ***not*** be written on the wristband for several reasons:

1. Legibility may hinder the correct interpretation of the allergy listed;

2. By writing allergies on the wristband someone may assume the list is comprehensive. However, space is limited on a wristband and some patients have in excess of 12 or more allergies. The risk is that some allergies would be inadvertently omitted – leading to confusion or missing an allergy;

3. 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 a wristband. By having one source of information to refer to, such as the medical record, staff of all disciplines will know where to add newly discovered allergies.

Recommendations for Adoption

Fall Risk

Recommendation:

It is recommended that hospitals adopt the color YELLOW for the Fall Risk designation with the letters "Fall Risk" embossed/printed on the wristband, clasp or label.

FAQs

Q. **Why did you select yellow?**

A. Our research of other industries tells us that yellow has an association that implies "Caution!" Think of the traffic lights; proceed with caution or stop altogether is the message with yellow lights. The American National Standards Institute (ANSI) has designated certain colors with very specific warnings. ANSI uses yellow to communicate "Tripping or Falling hazards." It fits well in health care too when associated with a Fall Risk. Caregivers would want to know to be on alert and use caution with a person who has history of previous falls, dizziness or balance problems, fatigability, or confusion about their current surroundings.

Q. **Why even use an alert band for Fall Risk?**

A. According to the Centers for Disease Control and Prevention (CDC), falls are an area of great concern in the aging population.

According to the CDC:

1. More than a third of adults aged 65 years or older fall each year.
2. Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes.
3. Of those who fall, 20% to 30% suffer moderate to severe injuries that reduce mobility and independence, and increase the risk of premature death.
4. The total cost of all fall injuries for people age 65 or older in 2000 was $19 billion (in current dollars).
5. By 2020, the cost of fall injuries is expected to reach $54.9 billion (in 2007 dollars). Hospital admissions for hip fractures among people over age 65 have steadily increased, from 230,000 admissions in 1988 to 320,000 admissions in 2004.
6. The number of hip fractures is expected to exceed 500,000 by the year 2040. As the aging population enters the acute care environment, one must consider the risk that is present and do all possible to communicate that to hospital staff. For more information about falls and related statistics, go to: http://www.cdc.gov/ncipc/factsheets/fallcost.htm

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

Recommendations for Adoption

Restricted Extremity

Recommendation:

It is recommended that hospitals adopt the color PINK for the Restricted Extremity designation with the letters "Restricted Extremity" embossed/printed on the wristband, clasp or label.

FAQs

Q. **Why did you select pink?**

A. Not all hospitals in Oklahoma use a wristband to denote restricted extremity, but many see the value and want to start this practice. Therefore, hospitals will have the option of using a pink wristband to signify restricted extremity if they so choose. Pink conforms to the national standard for restricted extremity alert color.

Q. **Why even use an alert for Restricted Extremity?**

A. The pink wristband has been used for breast cancer/lymphedema patients to indicate the extremity should not be used for starting an intravenous line or drawing laboratory specimens. Circulation is compromised in a patient with lymphedema and unnecessary invasive procedures should be avoided in the affected extremity. Pink wristbands can be used to indicate any other diagnosis that results in a restricted extremity.

Recommendations for Adoption

Latex Allergy

Recommendation:

It is recommended that hospitals adopt the color GREEN for the Latex Allergy Alert designation with the letters "Latex Allergy" embossed/printed on the wristband, clasp or label.

FAQs

Q. **Why even use an alert for Latex Allergy?**

A. Latex allergy may cause anaphylaxis, a potentially life-threatening condition.

Q. **Why did you select green?**

A. Similar to the optional use of the color pink for restricted extremity, the color green was chosen as an option to signify a patient allergy to latex. This is consistent with the national standard for latex allergy designation.

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 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" wristbands upon assessment, hand-off of care and 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 during the entrance to facility process and/or admission.
   b. Be sure this is addressed in your hospital policy.

4. **Initiate banding upon admission, changes in condition, or information received during hospital stay.**

5. **Educate patients and family members regarding purpose and meaning of the wristbands.**
   a. Including the family in this is a safe guard for you and the patient.
   b. Remind them 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 same color coding.**
   a. For allergies, fall prevention, DNR and restricted extremity status.

7. **Educate staff to verify patient color-coded "alert" wristbands upon assessment, hand-off of care and facility transfer communication.**

8. **When possible, limit the use of colored wristbands.**
   a. Such as, for other categories of care (i.e. MRSA, tape).

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 additional resource for verification process for allergies, fall risk, advance directives and restricted extremity.

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.**

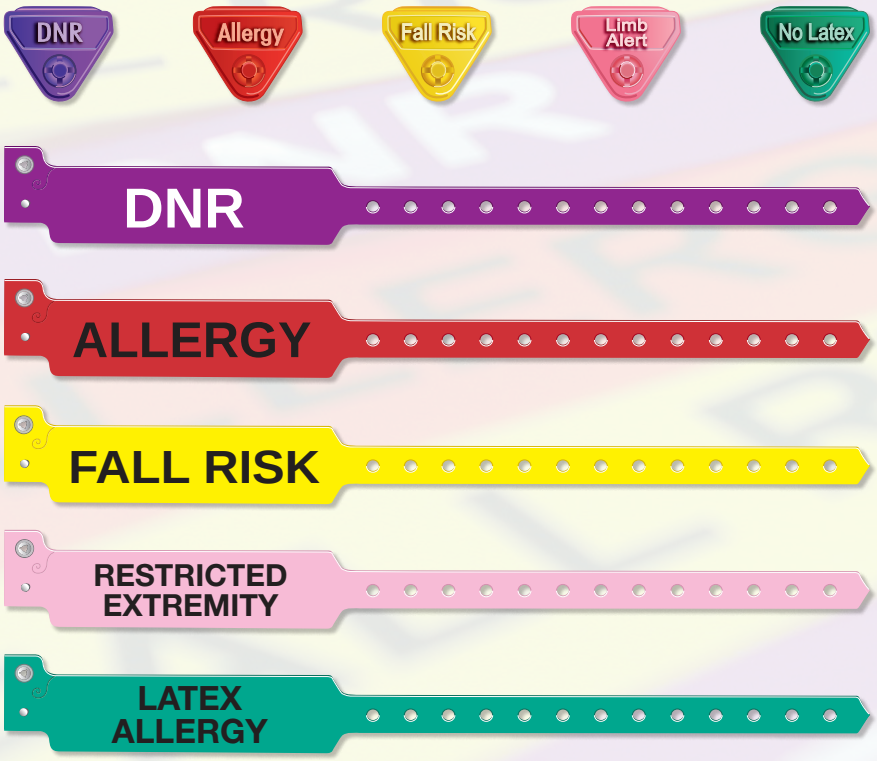
To improve patient safety in the delivery of health care has become a goal for every organization. A part of that is to reduce risks for injury or harm whenever possible. By implementing risk reduction strategies, we demonstrate patient safety in a consistent fashion.

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 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 claim 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 health care 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 health care facilities.

Work Plan — How to Implement



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

Area #1

Organizational Approval

See Task Chart for specific steps

Review

√ **Adopting this initiative may need approval by appropriate committees, such as:**

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

Action Plan

Organizations have different committees that need to approve system wide changes, or changes that directly impact patient care. Each organization needs to assess which committees need to approve the adoption of the initiative and begin to get on meeting agendas for approval. For some organizations this may mean simply presentation at one committee, such as The Patient Safety Committee. Other organizations would need to have this approved by several committees, depending on their culture.

Consider the stakeholders and be sure they approve and understand the initiative before it is implemented 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 are using for wristbands in Oklahoma. It is important to communicate to them that you are adopting the National model for color-coded wristbands (and adding an optional pink and green wristband). Most vendors are aware of the initiative and what bands should be ordered. However, if they do not know, inform them of the colors and that the alert message needs to be printed directly on the band (please see "Vendor Information" section). They do need some lead time for the imprinting (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 "back fill" into this date.

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 "back fill" into this date.

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

Area #3

Hospital Specific Documentation

Review

√ Policy adoption √ Assessment Revision √ Forms revised to meet standards √ Consents

Action Plan

Color-banding policy should be reviewed and approved if changes are made.

Hospitals should review their respective forms for possible modifications (pt. education assessments, etc.). You may want to include language that the patient received the wristband education brochure (See Patient Education section).

If a patient refuses to wear a band, do you have a document indicating this? Perhaps this needs to be discussed by your Patient Safety Committee. A sample has been provided in this Tool Kit.

Coordinate with: Risk Management Staff and individual Hospital Administrators

Area #4

Staff and Patient Orientation, Education and Training

Review

√ Schedule/training content √ Documentation requirement √ Posters & FAQs

Action Plan

Education format and training materials need to be reviewed.

Competency content and format has been standardized. The competency form may be individualized for the hospital.

Hospital staff education will need to be scheduled, completed and documented per hospital policy.

Make changes to the New Employee Orientation so they are provided current information.

Coordinate with: Individual Hospital Education Staff

Suggested Task Chart for Facility Preparation

Task Chart for Facility Preparation

Area #1 Organizational Approval & Awareness

STEP 1 When: **WEEK ONE** enter date this is done:_____

What to Do	Notes / Comments / Follow-ups		
Find out who the staff person is who supports the following committee meetings. Get the contact info for each one: ~ Patient Safety Committee ~ Medical Staff Committee ~ Nursing Practice Council ~ Quality Improvement Council ~ Board of Directors ~ Other? NOTE: Not all committees will need to approve this initiative; however, they will usually benefit from a presentation that provides the information about this initiative so they can support it. Seek guidance from your Administrative team to determine which meetings this needs to be presented to.	**Committee**	**Name**	**Email / ext.**
	Patient Safety Comm.		
	Medical Staff Comm.		
	Nursing Practice Council		
	Quality Improvement Council		
	Board of Directors		
	Other		
	Other		
	Other		

STEP 2 When: **WEEK ONE**

What to Do	Notes / Comments / Follow-ups		
Find out when the next meetings are and get on agenda to present the initiative for purpose of acquiring approval or conveying information. NOTE: Not all committees will need to approve this initiative; however, they will usually benefit from a presentation that provides the information about this initiative so they can support it. This is equally important and should be considered a priority as well.	**Committee**	**Date of Next Meeting**	**On Agenda? (Y / N)**
	Patient Safety Comm.		
	Medical Staff Comm.		
	Nursing Practice Council		
	Quality Improvement Council		
	Board of Directors		
	Other		
	Other		
	Other		

Task Chart for Facility Preparation

Area #1 Organizational Approval & Awareness continued

STEP 3 When: Pending Committee Approvals

What to Do	Notes / Comments / Follow-ups		
After presentations made and approval obtained to adopt recommendations, contact pertinent dept./staff to move forward. Convey info – see right column	**Dept.**	**Info to be Conveyed**	**Follow-ups**
	Materials Management	1. Approvals obtained. 2. OK to order wristbands. 3. When will bands be available? Take that date and add 5-7 more days – that is your "Go Live" date. (The 5-7 more days are added to allow for distribution of wristbands to pertinent areas.)	**How long until delivery?**
	Staff Education	1. Wristbands will be arriving in about _____ weeks. 2. "Go Live" Date is _____weeks. 3. OK to start education.	
	Risk Management and/or QI Director	1. Wristbands will be arriving in about _____ weeks. 2. "Go Live" date is _____weeks. 3. Confirm P&P has been approved and prepare to add to P&P manual.	
	Other Departments to consider: Medical Staff, Admitting, ED, Peri-Op, Nursing, Lab, Dietary, Laboratory, Radiology, Pharmacy, etc.	1. Wristbands will be arriving in about _____ weeks. 2. "Go Live" Date is _____weeks. 3. OK to start education. Coordinate with Education department for either materials / training / or information.	

Task Chart for Facility Preparation

Area #1 Organizational Approval & Awareness continued

STEP 4 If any other steps required, add them here.

What to Do	Notes / Comments / Follow-ups

STEP 5 If any other steps required, add them here.

What to Do	Notes / Comments / Follow-ups

STEP 6 If any other steps required, add them here.

What to Do	Notes / Comments / Follow-ups

Task Chart for Facility Preparation

Area #2 Supplies Assessment and Purchase

STEP 1 When: WEEK ONE enter date this is done:_____

What to Do	Other Notes / Cues
Contact Materials Manager and brief on the initiative. Answer questions and share the toolkit. Remember: You are just gathering information. Do not order wristbands until organizational approval has been obtained.	Coordinated with Materials Management (MM) person who will do the ordering. MM Name: _____ Email: _____ Phone: _____

STEP 2 When: WEEK ONE

What to Do	Other Notes / Cues
Ask Materials Manager when current supply of wristbands will run out. This is based on estimates from typical order patterns and staff usage.	Allergy Bands run out about _____ (ex: mid-Jan. 08) Fall Bands run out about _____ DNR Bands run out about _____ Restricted Extremity Bands run out about _____ Latex Allergy Bands run out about _____

STEP 3 When: WEEK ONE

What to Do	Other Notes / Cues
Ask Materials Manager to contact wristband vendor and alert them to change in supply color. Convey info to the right. Check off items once communicated to Vendor.	**ALLERGY Wristband:** ☐ Red: PMS 1788 ☐ "ALLERGY" pre-printed on wristband in black – 48 pt. Arial Bold, all caps **FALL Wristband:** ☐ Yellow: PMS 102 ☐ "FALL RISK" pre-printed on wristband in black – 48 pt. Arial Bold, all caps **DNR Wristband:** ☐ Purple: PMS 254 ☐ "DNR" pre-printed on wristband in white – 48 pt. Arial Bold, all caps **RESTRICTED EXTREMITY Wristband:** ☐ Pink: PMS 1905 ☐ "RESTRICTED EXTREMITY" pre-printed on wristband in black – 28 pt. Arial Bold, all caps **LATEX ALLERGY Wristband:** ☐ Green: Pantone Green ☐ "LATEX ALLERGY" pre-printed on wristband in black – 28 pt. Arial Bold, all caps

Task Chart for Facility Preparation

Area #2 Supplies Assessment and Purchase continued

STEP 4 When: WEEK TWO

What to Do	Other Notes / Cues
Follow-up with MM in a week and validate that they were able to contact vendor. Complete info in right column from MM.	Lead time required when ordering wristbands is: ALLERGY Wristband: _____ weeks FALL Wristband: _____ weeks DNR Wristband: _____ weeks RESTRICTED EXTREMITY Wristband: _____ weeks LATEX ALLERGY Wristband: _____ weeks

STEP 5

What to Do	When to Do It	Other Notes / Cues
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.	Give status report within a month of initial contact so MM knows this is still being worked on.	

STEP 6 If any other steps required, add them here.

What to Do	When to Do It	Other Notes / Cues

STEP 7 If any other steps required, add them here.

What to Do	When to Do It	Other Notes / Cues

Task Chart for Facility Preparation

Area #3 Hospital Specific Documentation

STEP 1 When: **week TWO or THREE** enter date this is done:_____

What to Do	Other Notes and Cues
Contact CNO and clinical directors to review if documentation records contain specific information about wristbands, such as daily nursing charting. **Remember: This is not a recommendation to add "wristbands" to your documentation process or color specific information, but to review your current documents / process.**	Coordinate with CNO and Clinical Directors It may be helpful or more efficient for you to pull the daily documentation information for the various areas and review the current requirement. Consider these documents: ED Triage record or Treatment / ED Nurses Notes Admitting Assessment ICU Nurses Notes Peri-Op Assessments / Notes Daily Nursing Documentation Other:_____

STEP 2 When: **week TWO or THREE**

What to Do	Other Notes and Cues
If your current documentation addresses wristband information, review documents to assure any reference to colors are updated to reflect these changes.	**Again, this is not a recommendation that the documentation reflect color information about wristbands. However, if your documentation is color specific, this is a cue to validate that the information be updated to reflect the new colors – if that is your current process.**

STEP 3 When: **week THREE or FOUR**

What to Do	Other Notes and Cues
If changes are required to the documentation forms, contact Forms Committee and pertinent Clinical Directors and initiate process for changes.	Some organizations require any changes to forms be reviewed through a "Forms Committee" or similar entity. Other organizations do not require this process if the information being changed is minimal and does not change "content." This step is to determine your organization's process.

STEP 4 When: **week THREE or FOUR**

What to Do	Other Notes and Cues
Once 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 in sync with the arrival of new documents.	

Task Chart for Facility Preparation

Area #3 Hospital Specific Documentation continued

STEP 5 When: week FOUR

What to Do	Other Notes and Cues
The Policy and Procedure for wristband application needs to be reviewed and updated to reflect the new process. Obtain a copy of the current wristband P&P and review content.	A sample P&P has been provided for you to use as a template. Review this sample and adopt its content as it makes sense in your organization. ***NOTE: It is important that you compare your current process with the sample P&P and determine what elements you will change. The sample P&P is not prescriptive but rather suggestive.***

STEP 6 When: week FOUR

What to Do	Other Notes and Cues
Some banding processes may vary slightly within the organization given the area of care and its unique needs, such as ED, Peri-Operative, Radiology, L&D, etc. You will want to contact the Directors of each of these areas and ask if they have their own P&P for banding a patient, or do they use the facility wide P&P. If they have a unique P&P, obtain a copy of it so you can compare its content with the facility wide P&P. Review with each area that has a unique P&P their current P&P and the proposed changes.	**Contact ED Director. Name/ext: _____** **Unique P&P? No_____ Yes_____ (obtain copy)** **Contact Peri-Op Director. Name/ext: _____** **Unique P&P? No_____ Yes_____ (obtain copy)** **Contact Radiology Director. Name/ext: _____** **Unique P&P? No_____ Yes_____ (obtain copy)** **Contact L&D Director. Name/ext: _____** **Unique P&P? No_____ Yes_____ (obtain copy)** **Contact "other" Director. Name/ext: _____** **Unique P&P? No_____ Yes_____ (obtain copy)** **Contact "other" Director. Name/ext: _____** **Unique P&P? No_____ Yes_____ (obtain copy)**

STEP 7

What to Do	Other Notes and Cues
Get this item on P&P committee agenda and have approval for the changes. Coordinate this with the departments that have "unique" P&Ps so all are changed at the same time.	P&P Committee Contact / ext. _____ Date / Month on P&P Committee _____ Communicate the P&P Committee date to other pertinent Directors so the proposed changes are reviewed and agreed upon before P&P Committee date.

Task Chart for Facility Preparation

Area #3 Hospital Specific Documentation continued

STEP 8 If any other steps required, add them here.

What to Do	Other Notes and Cues

STEP 9 If any other steps required, add them here.

What to Do	Other Notes and Cues

STEP 10 If any other steps required, add them here.

What to Do	Other Notes and Cues

Task Chart for Staff / Patient Education

Area #4 Staff and Patient Education

STEP 1 When: **TWO to THREE weeks**

What to Do	Other Notes and Cues
Familiarize yourself with training content and the tools (FAQs, brochures, Posters & more).	Review the contents of the Education session in this tool kit. This is important because as discussions occur about who will do what, you can inform Directors about the tools that are available for staff to use. Because the Education section is so comprehensive, some may opt to participate in the facilitation process. By giving the Directors all of the information about the tools and training section in this manual, they can make a better and informed decision.

STEP 2 When: **TWO to THREE weeks**

What to Do	Other Notes and Cues
Determine the education format by discussing with the Education Department and Clinical Directors. By education format we refer to the way the education is going to be managed - at the unit specific level or in a general session where multiple departments are present. Also, is the education going to be facilitated through the department specific Directors or Education department? It is important to consider all of the stakeholders: physicians, dietary, pharmacy, therapies, radiology, peri-op, ED, L&D, housekeeping, etc. The column on the right is a tool that you will need for all of the stakeholders. Use the back of this if more room is needed.	**Education Dept. preferences are:** ____ Unit Specific _____ General session ____ Other (explain_____) Facilitator Preferences: ____ Unit Based ____Educ Dept **Critical Care Dir. preferences are:** ____ Unit Specific _____ General session ____ Other (explain_____) Facilitator Preferences: ____ Unit Based ____Educ Dept **Med / Surg Dir. preferences are:** ____ Unit Specific _____ General session ____ Other (explain_____) Facilitator Preferences: ____ Unit Based ____Educ Dept **Pharmacy Dir. preferences are:** ____ Unit Specific _____ General session ____ Other (explain_____)

STEP 3 When: **THREE to FOUR weeks**

What to Do	Other Notes and Cues
Obtain the names of the trainers and send an email advising of an upcoming Train the Trainer. This meeting should be no longer than 45 minutes to one hour. Schedule this about one month out to accommodate already full schedules.	Whether training occurs at a unit-based level or in a general session, a Train the Trainer session ought to be considered so the Education Materials and Training Tips can be viewed by all.

Task Chart for Staff / Patient Education

Area #4 Staff and Patient Education continued

STEP 4 When: THREE to FOUR weeks

What to Do	Other Notes and Cues
Find out the name of Chair of the "Patient / Community Education" Committee. Contact that person and schedule appointment to review the Patient brochure. If necessary, get on the agenda of the next committee meeting to get approval for the brochure to be used.	Another component to the education section is the patient education. Most organizations have a "Patient / Community Education" Committee that reviews education materials before it can be given to patients.

STEP 5 When: TWO weeks before Train the Trainer Session

What to Do	Other Notes and Cues
Make one copy of the Education section of this tool kit for each Trainer so they each have their own set of materials. Don't forget about the PowerPoint presentation too. Some organizations may want to put the PowerPoint on a shared drive, while others may want to burn a copy of the CD.	Updates will be occurring to this tool kit as new information is added or great suggestions are made by the users. Be sure to visit the website where the tool kit is posted and check for any updates before you make all of the copies of materials. Our website is: http://www.okoha.com/wristbandalerttoolkit

STEP 6 When: THREE weeks before Staff Education Roll-out

What to Do	Other Notes and Cues
Send out a reminder email to all Trainers reminding them to make copies of the following hand outs for their staff: ~ Staff education brochure ~ Patient education brochure ~ FAQs ~ Posters announcing the meeting (there are three to choose from) ~ Sign-in sheet ~ Competency check list (if you are using that)	It may be useful to obtain the actual wristbands to show staff exactly what they look like. Also, try to incorporate some fun into this by using purple, red, yellow, green and pink "props" or candy – like M&Ms, Skittles or other such things.

STEP 7 If any other steps required, add them here.

What to Do	Other Notes and Cues


DNR
ALLERGY
FALL RISK
Staff and Patient Education Materials
DNR
Allergy
Fall Risk
Limb Alert
No Latex
DNR
ALLERGY
FALL RISK
RESTRICTED EXTREMITY
LATEX ALLERGY

Staff Education Training Tips

Introduction

The following section regarding staff education has been developed knowing that you may choose to do all of this, or part of it. We hope that we have made this section comprehensive without being overly burdensome. Make this plan work for you; use what you want and remember the goal is to communicate the changes with color-coded alert wristbands to your staff.

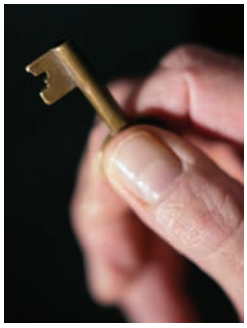
This section was created with the following design objectives in mind:

1. **Staff can be easily guided through the changes with color-coded alert wristbands;**
2. **The instructors are well equipped to teach about these changes;**
3. **No new materials have to be created by staff; this should be nearly a "turn key" education event, and**
4. **Staff can feel confident that all Oklahoma hospitals are hearing the same message and a similar implementation plan. This is important if staff work at more than one hospital.**

Who and how will this be done?

This is a decision that needs to be made within your organization. It can be as simple or formal as you desire. Suggestions include staff meetings, at formal education sessions, annual competencies – what ever works for your organization. It should be done routinely at new employee orientation so the new staff is quickly brought up to speed on this initiative.

Key Preparation Before You Start



Review your section under the "Implementation Work Plan" to be sure you have included all of your stakeholders in this process. Consider all of the stakeholders in your organization when it comes to color-coded wristbands and who is impacted in this system change.

Thoughts to consider:

1. **While ultimately the nurses are the people that usually band the patient, the clerks/secretaries are greatly involved in the system process. Include them in the training. They can better assist the nurses when they have this information.**

2. **Consider the housekeeping staff. They are often present in a patient room when a patient is trying to get up or walking to the bathroom. If the housekeeping staff knows a yellow wristband means "Fall Risk," and they see a patient trying to get up, they can call the nursing staff, alert them and potentially prevent a fall.**

3. **What about the dietary technicians? A red wristband means there is an allergy – and not just to medicines. Maybe it is a food allergy and the red band will alert them to check for that and note it in their profile.**

4. **Don't make assumptions about the Medical Staff getting this information. Attendings, Intensivists, Residents and Interns need to know what these colors mean. Pull them into the process. This promotes safe health care for all providing it and receiving it.**

5. **Who else? Take some time to quietly observe the activities of the day at one of the nurse's stations. Just a 30 minute observation and you will probably "see" and "hear" things that make you remember another stakeholder. Include them in the education process. Once done, you can begin the actual training part.**

Getting Started

Most people will use this brochure as the main teaching material. It contains most of the pertinent information staff need to know for this initiative. ***We suggest you do not give out the brochure until the end of your training because people may start reading the brochure instead of listening to you.*** Pass it out at the end of the meeting, but tell them up front that there is a brochure with all of the information you are presenting and you will pass it out later.

Here are the main points you want to make during your training session:

1 **Start with a story** – adults want to know "why" they should do something; simply telling them they need to start doing this "because they do" is not sufficient information to get high levels of compliance. Besides, isn't that what you would want to know, too? A story gives them information that makes the request relevant – so they want to comply.

This story is true. One panel of the brochure tells the story where a patient was not coded due to a mix up in the wristbands. The error was caught in time to quickly code the patient, but by telling this story most staff will understand how this error could happen to anyone – and they will be on board with this plan. The story goes like this:

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

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

2 **The Big Picture** – Educate the staff about the current workforce conditions in Oklahoma such as high turnover rates and a high number of agency and traveling nurses, which can contribute to confusion and possible errors when different hospitals use different color alerts. Share with the staff the state and national efforts to standardize wristband colors and that over half of all states have already adopted AHA's recommended standards.

Hospitals in Oklahoma had many different categories of wristbands being used to designate DNR status, Fall Risk and Allergy. The risk for errors was obvious. The solution: standardize the colors being used for Allergies, Fall Risk, DNR, Restricted Extremity and Latex Allergy in all Oklahoma Hospitals. Our answer is this project.

This initiative is being adopted by hospitals throughout the nation. This will make it safer for us as clinicians and as patients. Once achieved, it means whether you are traveling on vacation to these states or relocated to work in another state, participating hospitals will be using the following colors:

RED means ALLERGY ALERT

YELLOW means FALL RISK

PURPLE means "DNR" or Do Not Resuscitate

PINK means RESTRICTED EXTREMITY

GREEN means LATEX ALLERGY

3

Introduce the Colors – In the tool kit you will find five sample wristbands that show the colors being used and demonstrate the text that is pre-printed on the wristbands. These wristbands are from the vendor The St. John Companies, Inc. If your organization uses a different vendor (check with Materials Management), then you may want to check to see if their bands are available so you can show what you will be using. The colors should be the same since the vendors know the "colors" being used. This is the time to show the bands so there is a visual of the information you are going to share. Review with staff the five bands, the colors and the corresponding meaning. The text box below will walk you through that information.

There are five different color-coded "alert" wristbands that we are going to discuss that are a part of the statewide standardization.

RED means ALLERGY ALERT

YELLOW means FALL RISK

PURPLE means "DNR" or Do Not Resuscitate

PINK means RESTRICTED EXTREMITY

GREEN means LATEX ALLERGY

4

FAQs about the colors selected. This is a companion document to the staff brochure. Research about colors and human association with certain colors contributed to the color selection process in this project. This is important for staff to know so they can feel confident with this process. The FAQ document reviews why the colors were selected and why other colors were not selected. At this time, hand out the FAQ sheet to staff and review with them. Don't just hand out the FAQs. Make this interactive and ask each person attending to take a question (there are 12) and read the answer to all. This will make the session more interesting. Also, by having staff read and hear the information, they will "re-engage" at this point in the presentation.

You are two-thirds done at this point. Let staff know this so they mentally relax.

5

Seven Risk Reduction Strategies – In addition to the standardization of wristband colors in the state, we recommend seven other risk reduction strategies that should be initiated. These are suggested as a result of sentinel events that have occurred, near-miss events and common sense. This information is also in the staff brochure and can be cut out as a Quick Reference Guide and laminated, if you desire. Review these with staff now.

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 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" wristbands upon assessment, hand-off of care and 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 during the entrance to facility process and/or admission.
   b. Be sure this is addressed in your hospital policy.

4. **Initiate banding upon admission, changes in condition, or information received during hospital stay.**

5. **Educate patients and family members regarding purpose and meaning of the wristbands.**
   a. Including the family in this is a safe guard for you and the patient.
   b. Remind them 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 same color coding.**
   a. For allergies, fall prevention, DNR and restricted extremity status.

7. **Educate staff to verify patient color-coded "alert" wristbands upon assessment, hand-offs of care and facility transfer communication.**

Additional points to make:

8. **When possible, limit the use of colored wristbands.**
    a. Such as, for other categories of care (i.e. MRSA, tape).

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 additional resource for verification process for allergies, fall risk, advance directives and restricted extremity.

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.**

6

Teaching Patients - The Patient Education brochure is a companion document to the staff brochure. We know that ***how*** we say something is just as important as ***what*** we say. Patients and their loved ones are scared, vulnerable and unfamiliar with hospital ways. We need to communicate to them in a respectful and simple way without being condescending. The following text was written to serve as a "script" for staff so all could be delivering the same information to patients and families. By having a consistent message, we reinforce the information – this helps patients and families retain the information. Another benefit of having a consistent message is patients and families experience a sense of confidence in the health care system since we are all echoing each other. The text box below is taken directly from the staff brochure. This is the time to mention to staff there is a patient / family brochure that can be handed out (if your unit intends on doing that). Tell staff you will hand out the brochure to them so they can see what the patients will have when you are done presenting the material.

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 FIVE different color-coded "alert" wristbands that we are going to discuss because they are going to be standardized throughout the state.

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 they receive.

YELLOW means FALL RISK
We want to prevent falls at all times. Nurses review 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 saying this person needs to be assisted when walking or they may fall.

PURPLE means "DNR" or Do Not Resuscitate
Some patients have expressed an end-of-life wish and we want to honor that request.

PINK means RESTRICTED EXTREMITY
When a patient has this color-coded wristband, the nurse is saying this patient's extremity should be handled with extreme care. Other care providers are alerted to check with the nurse prior to any tests or procedures involving the restricted extremity.

GREEN means LATEX ALLERGY
The best way to prevent an allergic reaction is to avoid latex. This green wristband will alert the doctors, nurses and other health care professionals about your allergy.

7

And finally…. Review with staff the points listed below. These are the items that are listed on the competency so it is important to clarify that they have a good understanding of these items. You should emphasize, "this is what would impact your tasks every day…" and review those points. This is a good time to hand out your organization's Policy and Procedure. Be sure your policy covers the below listed areas as they are also a part of the competency. If your policy does not address any of the items on the competency, then you should remove it from the form.

- ✓ Color Code – what do the five colors mean?
- ✓ Who can apply the wristband to the patient?
- ✓ When does the application of the color-coded wristband(s) occur?
- ✓ Policy on patients not allowed to wear the "Social Cause" bands
- ✓ Patient education and how to communicate (script) the information with patients /families
- ✓ Need for Re-Application of Band
- ✓ Communication re wristbands during transfers and other reports.
- ✓ Patient refusal to comply with policy
- ✓ Discharge Instructions for home and /or facility transfer

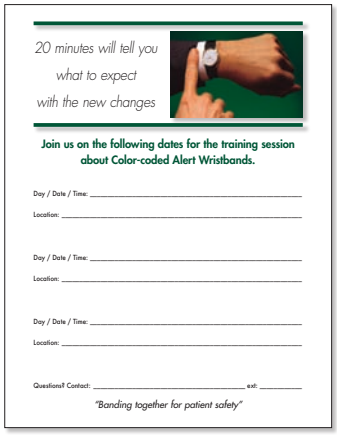
Training materials are available online in a pdf file. To access them, go to our website at:
http://www.okoha.com/wristbandalerttoolkit

Staff Education — The Tools

1. Poster announcing the training meeting dates/times

(Document Provided)

The following posters were created to announce the meetings and the initiative. Post them in the staff lounge, communication boards, employee locker room, staff bath rooms, where ever you feel staff will see it.



Training materials are available online in a pdf file. To access them, go to our website at:
http://www.okoha.com/wristbandalerttoolkit

20 minutes will tell you

what to expect

with the new changes

Join us on the following dates for the training session about Color-coded Alert Wristbands.

Day / Date / Time: _____

Location: _____

Day / Date / Time: _____

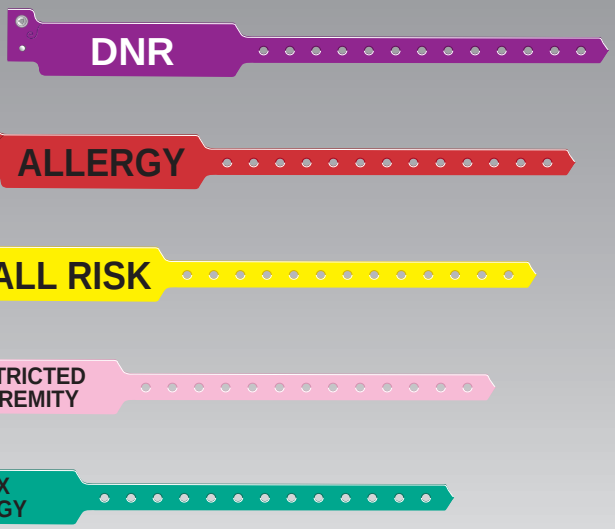
Location: _____

Day / Date / Time: _____

Location: _____

Questions? Contact: _____ ext: _____

"Banding together for patient safety"



Join us on the following dates for the training session about Color-coded Alert Wristband Standardization.

Day / Date / Time: _____

Location: _____

Day / Date / Time: _____

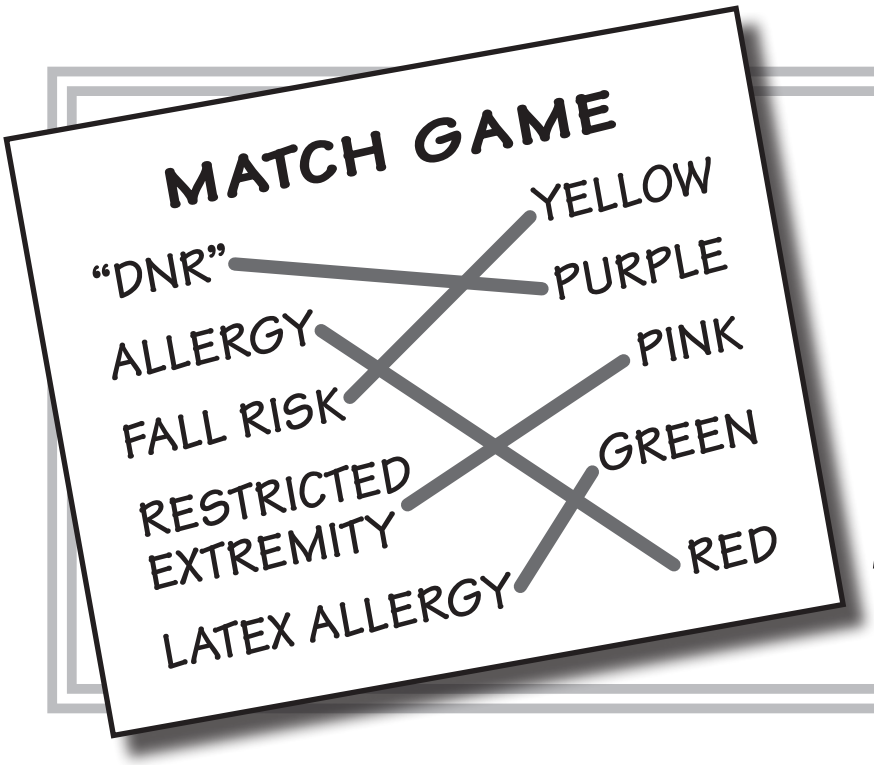
Location: _____

Day / Date / Time: _____

Location: _____

Questions? Contact: _____ ext: _____

"Banding together for patient safety"



Colors are FUN but patient safety is NOT A GAME

Join us on the following dates for the training session about Color-coded Alert Wristband Standardization.

Day / Date / Time: _____

Location: _____

Day / Date / Time: _____

Location: _____

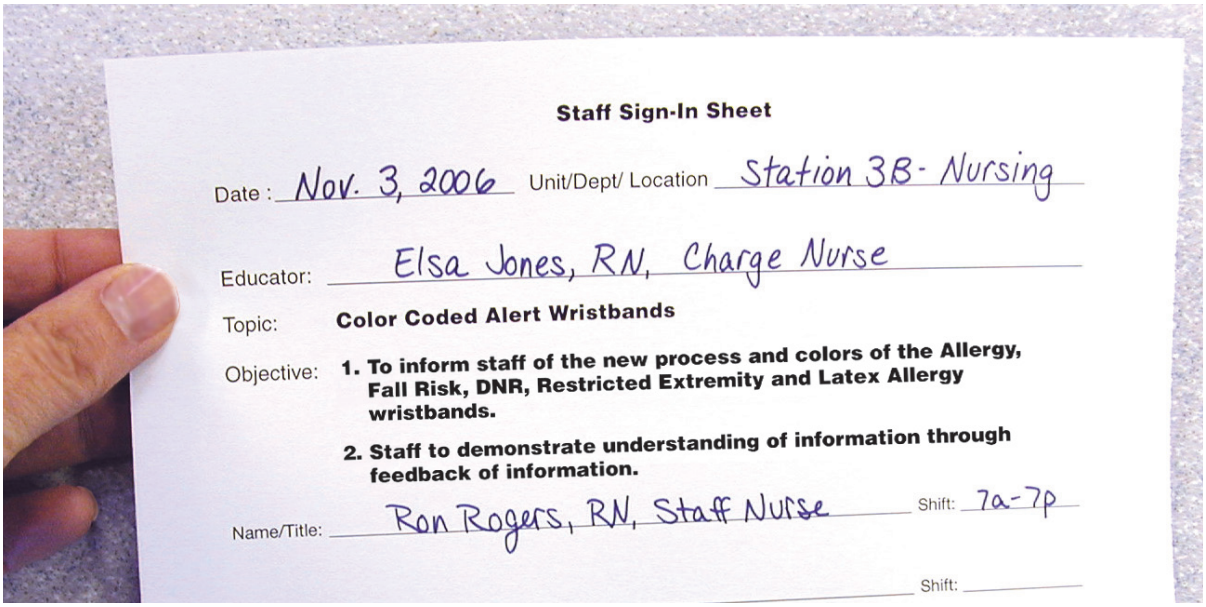
Day / Date / Time: _____

Location: _____

Questions? Contact: _____ ext: _____

Staff Education — The Tools continued

2. Staff Sign-In Sheet (Document Provided)



Staff Sign-In Sheet

Date : Nov. 3, 2006 Unit/Dept/ Location Station 3B - Nursing

Educator: Elsa Jones, RN, Charge Nurse

Topic: Color Coded Alert Wristbands

Objective: 1. To inform staff of the new process and colors of the Allergy, Fall Risk, DNR, Restricted Extremity and Latex Allergy wristbands.

2. Staff to demonstrate understanding of information through feedback of information.

Name/Title: Ron Rogers, RN, Staff Nurse Shift: 7a-7p

Shift:

Sample — Completed Staff Sign-In Sheet

- Use this form so there is a record of all staff that attended the training session.
- Make copies so you don't use the last one.
- If you use the last one, go to **http://www.okoha.com/wristbandalerttoolkit**.
- Keep this sign-in sheet with your staff meeting / training folder. The Joint Commission or other regulatory agencies may ask you for it. This is especially important if you are making this a mandatory participation session.

Staff Sign-In Sheet

Date :_____ Unit/Dept/ Location _____

Educator: _____

Topic: **Color-coded Alert Wristbands**

Objective:

1. **To inform staff of the new process and colors of the Allergy, Fall Risk, DNR, Restricted Extremity and Latex Allergy wristbands.**
2. **Staff to demonstrate understanding of information through feedback of information.**

Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

Staff Education — The Tools continued

3. Staff competency check list (Document Provided)

We recognize that some organizations will opt to use this form and some will not. Should you decide to use a competency check list in your process, we hope this form will provide the documentation you need. This form also serves as a great check list for the trainer so all of the important elements in the training are remembered and taught.

If you do not use this as a staff form, consider using it as your form to help you remember every element you should be reviewing with staff about the changes with the color-coded alert wristbands.

Training materials are available online in a pdf file. To access them, go to our website at:
http://www.okoha.com/wristbandalerttoolkit

Staff Competency Checklist

Purpose: These are the standards of the technical competencies necessary for performance and/or clinical practice.

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

Supervisor's initials signify competency was met.

Methods to Use:

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

Employee Name _____ Job Title _____

Patient Color-coded Alert Wristband Process	Date	Method Used	Supervisors' Initials	Comments
Color Code – what do the five colors mean?				
Who can apply the wristband to the patient?				
When does the application of the wristband(s) occur?				
Policy on patient's not allowed to wear the "Social Cause" bands				
Patient education and how to communicate (script) the information with patients /families				
Need for Re-Application of Band				
Communication re wristbands during transfers and other reports				
Patient refusal to comply with policy				
Discharge Instructions for home and /or facility transfer				

Signature _____ Initials _____

Signature _____ Initials _____

Employee Signature _____ Date _____

Staff Education — The Tools continued

4. Tri-fold brochure called "Staff Education Regarding: Color-coded "alert" Wristbands"

(Document provided)

Most people will use this brochure as the main teaching material. It contains most of the pertinent information staff need to know for this initiative. We suggest you do not give out the brochure until the end of your training because people may start reading the brochure instead of listening to you. Pass it out at the end of the meeting, but tell them up front that there is a brochure with all of the information you are presenting and you will pass it out later.

5. Tri-fold brochure called "Patient Safety: Understanding what your color-coded "alert" wristbands mean"

(Document provided in English and Spanish)

This brochure was created to hand out to patients and family members so they understand what the wristband colors mean and can confirm the information. Patients should have this information whether they need a color-coded wristband, or not, because new information may surface due to this education. For example, perhaps a patient has an allergy to a certain food but was thinking only about medications when first asked about allergies. During a family visit, a loved one could read this information brochure and bring up the food allergy. This can now be corrected and the patient is not at risk due to an oversight.

Training materials are available online in a pdf file. To access them, go to our website at:
http://www.okoha.com/wristbandalerttoolkit

How this all got started...

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

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

What about Oklahoma?

Oklahoma has a goal of providing safe and high quality care. We accomplish this in several ways, one which includes using the same colors for "alert" wristbands. Most hospitals are adopting the same colors so regardless of which hospital you work at today or tomorrow, the color coded alert wristbands should be the same color for Allergy, the same color for Fall Risk, the same color for Do Not Resuscitate, the same color for Restricted Extremity, and the same color for Latex Allergy.

The National Picture

The Big Picture - This initiative is being adopted by hospitals nationwide. The American Hospital Association has released a policy encouraging nationwide adoption of these standard colors, and most states have adopted all or some of the standard colors or are in the process of standardizing."

RED means ALLERGY ALERT

YELLOW means FALL RISK

PURPLE means "DNR" or Do Not Resuscitate

PINK means RESTRICTED EXTREMITY

GREEN means LATEX ALLERGY

OHA Oklahoma Hospital Association

Staff Education Regarding:

Color-coded "alert" wristbands

Information intended for all staff, clinical and non-clinical.

Color-coded Alert Wristbands – A Statewide Patient Safety Initiative

Hospitals in Oklahoma had many different categories of wristbands being used to designate DNR status, Fall Risk and Allergy. With a high nursing turnover rate and a large number of agency and traveling nurses in Oklahoma, the risk for errors was obvious. The solution: standardize the colors being used for Allergies, Fall Risk, DNR, Restricted Extremity and Latex Allergy in all Oklahoma Hospitals. Our answer is this project.

How to tell the patients what the different colors mean?

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

SCRIPT

For any staff person talking to a patient or family

What 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 FIVE different color-coded "alert" wristbands that we are going to discuss because they are going to be standardized throughout the state.

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 they receive.

YELLOW means FALL RISK
We want to prevent falls at all times. Nurses review 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 saying this person needs to be assisted when walking or they may fall.

PURPLE means "DNR" or Do Not Resuscitate
Some patients have expressed an end-of-life wish and we want to honor that request.

PINK means RESTRICTED EXTREMITY
When a patient has this color-coded wristband, the nurse is saying this patient's extremity should be handled with extreme care. Other care providers are alerted to check with the nurse prior to any tests or procedures involving the restricted extremity.

GREEN means LATEX ALLERGY
The best way to prevent an allergic reaction is to avoid latex. This green wristband will alert the doctors, nurses and other health care professionals about your allergy.

Other Risk Reduction Strategies Staff Should Know

Color-coded "Alert" Wristbands / Risk Reduction Strategies

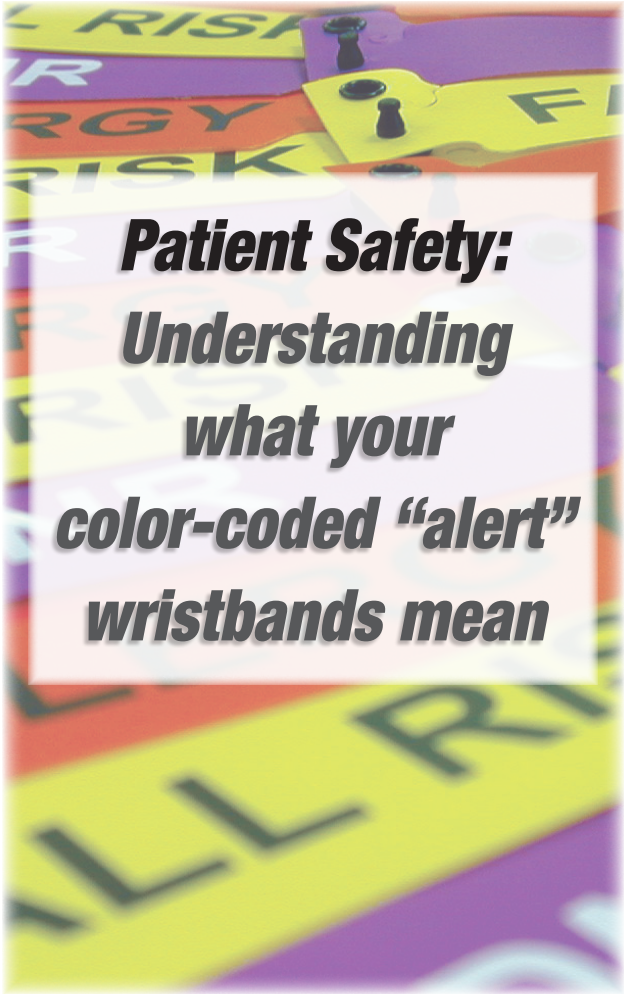
Quick Reference Card

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 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" wristbands upon assessment, hand-off of care and facility transfer communication.

Our hospital is proud to be a supporter of this collaborative work, making health care safer and better for patients and their families.

Oklahoma health care providers are working together to make patients safe. We accomplish this goal by working together on statewide projects in an endeavor to use the same methods or processes, like color-coded wristbands.

Oklahoma Hospital Association



Patient Safety: Understanding what your color-coded "alert" wristbands mean

Statewide Patient Safety Initiatives

Patient safety is a priority in Oklahoma. We accomplish this in several ways, one that includes all hospitals using the same colors in their alert bracelets. This initiative is not only in Oklahoma, but is now in most states.

What is a Color-coded "Alert" Wristband?

Alert wristbands are used in hospitals to quickly communicate a certain health care status or an "alert" that a patient may have. This is done so every staff member can provide the best care possible, even if they do not know that patient. The different colors have certain meanings. The words for the alerts are also written on the wristband to reduce the chance of confusing the alert messages.

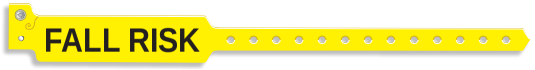
What do the different colors mean?

There are five different color-coded "alert" wristbands that have been standardized throughout the state.

RED means ALLERGY ALERT

If you have 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 you receive.

YELLOW means FALL RISK



We want to prevent falls at all times. Your provider will determine if you 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, it indicates this person needs to be assisted when walking or they may fall.

PURPLE means "DNR" or Do Not Resuscitate

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

PINK means Restricted Extremity

When a patient has this color-coded wristband, the health provider is saying this patient's extremity should be handled with extreme care. Other care providers are alerted to check with the nurse prior to any tests or procedures.

GREEN means Latex Allergy

When a patient has this color-coded wristband, it indicates an allergic reaction to latex. This green wristband will alert the doctors, nurses, and other health care professionals about your allergy.

Involving Patients and Family Members

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

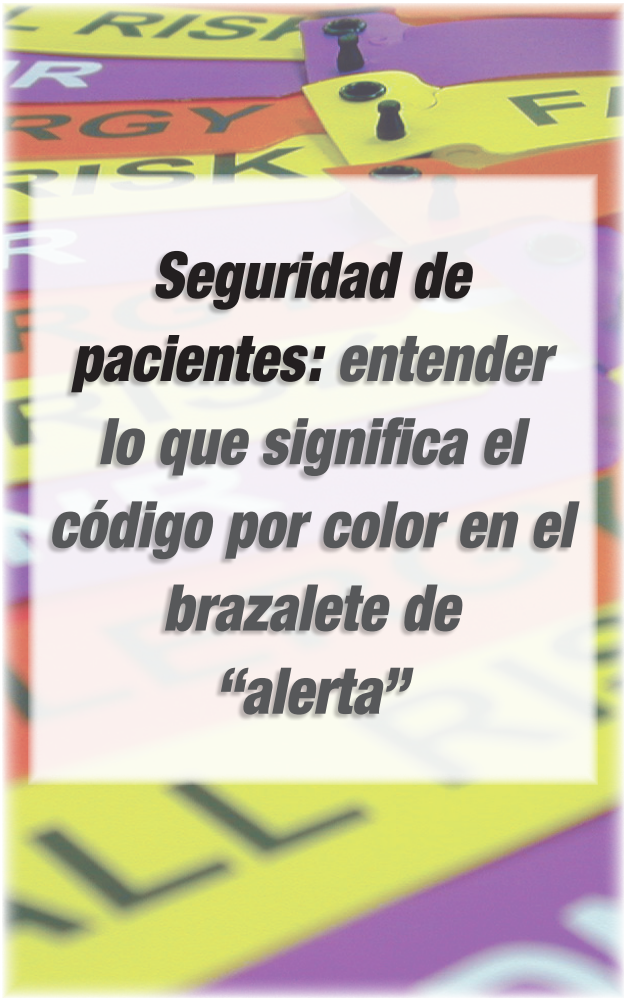
Keep us informed.
If there is information we do not know, such as a food allergy or a tendency to lose balance and almost fall, share that with us because we want to provide the best and safest health care to all of our patients.

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

Nuestro hospital está orgulloso de apoyar este trabajo de colaboración para permitir que haya mejor atención médica y más segura para los pacientes y sus familias.

Los proveedores de atención médica de Oklahoma están trabajando conjuntamente para lograr que Oklahoma sea el estado más seguro en la nación. Alcanzaremos esta meta trabajando juntos en proyectos a nivel estatal en un esfuerzo por usar los mismos métodos o procesos, como los brazaletes de código por color.

OHA
Oklahoma Hospital Association



Seguridad de pacientes: entender lo que significa el código por color en el brazalete de "alerta"

Iniciativas Estatales para la Seguridad de Pacientes

La seguridad de los pacientes es una prioridad en Oklahoma. Logramos esto de varias maneras, una que incluye todos los hospitales utilizando los mismos colores en sus pulseras de alerta. Esta iniciativa no es sólo en Oklahoma, pero se encuentra ahora en la mayoría de los estados.

¿Qué es un brazalete de "alerta" de código por color? Pacientes y Familiares

Los brazaletes de alerta se usan en los hospitales para comunicar rápidamente un cierto estado de atención médica o una "alerta" que el paciente pueda tener. Esto se lleva a cabo para que cada miembro del personal pueda proporcionar la mejor atención posible, aún y cuando no conozca al paciente. Los diferentes colores tienen significados determinados. Las palabras para las alertas también están escritas en el brazalete para reducir la posibilidad de confundir los mensajes de alerta.

¿Qué significan los diferentes colores?

Hay cinco diferentes códigos de color para los brazaletes de "alerta" a los que nos vamos a referir debido a que son los más usados comúnmente.

ROJO significa ALERTA DE ALERGIA

Si un paciente tiene una alergia a algo – alimento, medicina, polvo, pasto, pelo de animal, CUALQUIER COSA – por favor infórmenoslo. Tal vez no le parezca de gran importancia a usted pero podría ser sumamente importante para la atención que reciban.

AMARILLO significa RIESGO DE CAÍDA

En todo momento queremos prevenir las caídas. Las enfermeras revisan a los pacientes todo el tiempo para determinar si necesitan atención adicional para prevenir una caída. Algunas veces, una persona podría debilitarse durante el curso de su enfermedad o debido a que acaba de tener una cirugía. Cuando un paciente tiene un brazalete de alerta con este código de color, la enfermera está diciendo que esta persona necesita recibir ayuda al caminar o podría sufrir una caída.

MORADO significa NO RESUCITAR ("DNR", por sus siglas en inglés)

Algunos pacientes han expresado un deseo de no ser resucitados en caso de ser requerido para conservarlos con vida y queremos respetar ese deseo.

ROSADO significa Extremidad Restringida

Cuando un paciente tiene un brazalete con este código de color, el proveedor de cuidado de la salud está indicando que la extremidad de este paciente debe ser manejada con extremo cuidado. Se alerta a otros proveedores de cuidado de la salud que deben consultar con la enfermera antes de realizar cualquier prueba o procedimiento.

VERDE significa Alergia al Látex

Cuando un paciente tiene un brazalete con este código de color, indica que tiene reacción alérgica al látex. Este brazalete verde alertará a los doctores, enfermeras y otros profesionales del cuidado de la salud sobre su alergia.

Involucrando a los pacientes y a los familiares

Es importante que el paciente y su familia conozcan estos colores y sus significados porque usted en nuestra mejor fuente de información.

Manténganos informados.

Si hay información que no conocemos, tales como alergias a alimentos o una tendencia a perder el equilibrio y caerse, comparta esta información con nosotros porque queremos proporcionar la mejor y más segura atención médica para todos nuestros pacientes.

Además, si usted cuenta con una Directiva por Adelantado, díganoslo. Una Directiva por Adelantado le informa a su doctor el tipo de atención que usted desearía si usted se ve imposibilitado de tomar decisiones médicas. Queremos respetar y hacer honor a los deseos de los pacientes y ello se puede lograr mejor cuando tenemos toda la información.

Staff Education — The Tools continued

6. FAQ handout for staff (Document Provided)

This handout was created to offer further clarification regarding the changes being made.
You can use this as a handout or to post in staff areas as well.

Training materials are available online in a pdf file. To access them, go to our website at:
http://www.okoha.com/wristbandalerttoolkit

FAQs about Color-coded Alert Wristbands

Q#1. We don't use wristbands for DNRs at this hospital. Why should we consider adopting this?

A. Wristbands are used in many Oklahoma hospitals to communicate an alert. Registry staff, travelers, non-clinical staff, etc. may be unaware of where to look in the medical record if they are new to your hospital. By having a wristband on, a quick warning is communicated so anyone could know about this alert. Additionally, it is also a means to communicate to the family that we are clear about their end-of-life wishes. By not having a band on, errors of omission could potentially be created.

Q#2. Why not use Blue?

A. The work group considered the work in Arizona, and the over 30 other states that have subsequently adopted purple to standardize DNR, and the rationale behind their decisions. It also took into consideration that a majority of Oklahoma hospitals call a code by announcing "Code Blue." By also having a blue DNR wristband and a "code blue" call, there was the potential to create confusion. Clinicians might ask, "Does blue mean we code or do not code?" To avoid creating any second-guessing in this situation, the decision was made to adopt the same guideline as in the majority of states — purple to designate DNR.

Q#3. Why not Green?

A. Again, we considered this color as well; however, due to color-blindness concerns, we decided to avoid it altogether. Also, in other settings the color green often has a "Go Ahead" connotation, such as traffic lights. We again want to avoid any possibility of sending "mixed messages" in a critical moment.

Q#4. So, if we adopt the purple DNR wristband then do we still need to look in the chart?

A. Yes. Some hospitals do not use wristbands for DNRs because they want the chart to be reviewed first for the most current code designation. However, that practice should be the practice in all cases – whether a wristband is being used or not. Code status can change throughout a hospitalization. It is important to know the current status so the patient's and family's wishes can be honored.

Q#5. Why did you select red?

A. Red was selected based on the fact that many hospitals currently use red to denote allergies. Even though some hospitals use red with blood typing, there were an equal number using it for allergies, and it seemed to have the connotation of stopping before proceeding.

Q#6. Are there any other reasons for using red?

A. Yes there are. Our research of other industries tells us that red has an association that implies extreme concern. The American National Standards Institute (ANSI) has designated certain colors with very specific warnings. ANSI uses red to communicate "Stop!" or "Danger!" We think that message should hold true for communicating an allergy status. When a caregiver sees a red allergy alert wristband they are prompted to "STOP!" and double check if the patient is allergic to the medication, food, or treatment they are about to receive.

Q#7. Do we write the allergies on the wristband too?

A. It is our recommendation that allergies be written in the medical record according to your hospital's policy and procedure. We suggest allergies not be written on the wristband for several reasons:

1. Legibility may hinder the correct interpretation of the allergy listed;
2. By writing allergies on the wristband someone may assume the list is comprehensive. However, space is limited on a wristband and some patients have in excess of 12 or more allergies. The risk is that some allergies would be inadvertently omitted – leading to confusion or missing an allergy;
3. 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 a wristband. By having one source of information to refer to, such as the medical record, staff of all disciplines will know where to add newly discovered allergies.

FAQs about Color-coded Alert Wristbands continued

Q#8. Why did you select yellow?

A. Our research of other industries tells us that yellow has an association that implies "Caution!" Think of the traffic lights; proceed with caution or stop altogether is the message with yellow lights. The American National Standards Institute (ANSI) has designated certain colors with very specific warnings. ANSI uses yellow to communicate "Tripping or Falling hazards." It fits well in health care too when associated with a Fall Risk. Caregivers would want to know to be on alert and use caution with a person who has history of previous falls, dizziness or balance problems, fatigability, or confusion about their current surroundings.

Q#9. Why even use an alert band for Fall Risk?

A. According to the Centers for Disease Control and Prevention (CDC), falls are an area of great concern in the aging population.

According to the CDC:

1. More than a third of adults aged 65 years or older fall each year.
2. Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes.
3. Of those who fall, 20% to 30% suffer moderate to severe injuries that reduce mobility and independence, and increase the risk of premature death.
4. The total cost of all fall injuries for people age 65 or older in 2000 was $19 billion (in current dollars).
5. By 2020, the cost of fall injuries is expected to reach $54.9 billion (in 2007 dollars). Hospital admissions for hip fractures among people over age 65 have steadily increased, from 230,000 admissions in 1988 to 320,000 admissions in 2004.
6. The number of hip fractures is expected to exceed 500,000 by the year 2040. As the aging population enters the acute care environment, one must consider the risk that is present and do all possible to communicate that to hospital staff. For more information about falls and related statistics, go to: http://www.cdc.gov/ncipc/factsheets/fallcost.htm

Q#10. Why did you select pink?

A. Not all hospitals in Oklahoma use a wristband to denote restricted extremity, but many see the value and want to start this practice. Therefore, hospitals will have the option of using a pink wristband to signify restricted extremity if they so choose. Pink conforms to the national standard for restricted extremity alert color.

Q#11. Why even use an alert for Restricted Extremity?

A. The pink wristband has been used for breast cancer/lymphedema patients to indicate the extremity should not be used for starting an intravenous line or drawing laboratory specimens. Circulation is compromised in a patient with lymphedema and unnecessary invasive procedures should be avoided in the affected extremity. Pink wristbands can be used to indicate any other diagnosis that results in a restricted extremity.

Q#12. Why even use an alert for Latex Allergy?

A. Latex allergy may cause anaphylaxis, a potentially life-threatening condition.

Q#13. Why did you select green?

A. Similar to the optional use of the color pink for restricted extremity, the color green was chosen as an option to signify a patient allergy to latex. This is consistent with the national standard for latex allergy designation.

For questions or comments regarding this project, please direct to:

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4000 Lincoln Blvd.
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Staff Education — The Tools continued

7. PowerPoint (with speaker notes)

This presentation was created to provide alternate teaching methods for the trainer. It can be used in large and small groups. Please check our website periodically as we will update the presentation as needed. To do that, go to **http://www.okoha.com/wristbandalerttoolkit**. The CD in your tool kit also contains this PowerPoint presentation.

Color-coded Wristband
Standardization in Oklahoma

"Banding Together for Patient Safety" 1

Color-coded Wristband
Standardization in Oklahoma
Executive Summary

Background:

- **In Pennsylvania there was confusion regarding wristband color that resulted in a patient being labeled DNR erroneously.**
- **In 2008, the American Hospital Association (AHA) issued a quality advisory recommending that hospitals consider using certain standardized colors for alert wristbands.**

"Banding Together for Patient Safety" 2

Color-coded Wristband
Standardization in Oklahoma
Executive Summary

- **In early 2009, both the Greater Oklahoma City Hospital Council and the Tulsa Hospital Council approved the recommendations to accept the three American Hospital Association's recommended wristband alert colors (red for patient allergies, yellow for fall risk and purple for do not resuscitate patient preferences) for standardization within the two metro areas. They also recommended that hospitals adopt green for latex allergies and pink for restricted extremity use.**

"Banding Together for Patient Safety" 3

Color-coded Wristband
Standardization in Oklahoma
Executive Summary

- **The choice of color to designate certain conditions is not limited to wristbands. Any form of designation that is used for the five conditions must be consistent with the colors of the wristbands. For example, if labels or clasps are used in lieu of a wristband to alert clinicians of a certain medical condition; then the labels and clasps should be consistent with the color that should be used for the alert wristband.**

"Banding Together for Patient Safety" 4

Color-coded Wristband
Standardization in Oklahoma
Executive Summary

What about staff impact?

- **Nursing shortage/vacancies: in 2008, the Oklahoma Health Care Workforce Center cited that there were 1,662 nursing vacancies in Oklahoma hospitals**
- **Nursing turnover rate is 17.5%**
- **Hospitals are using agency and traveling nurses to staff vacant positions**

"Banding Together for Patient Safety" 5

Color-coded Wristband
Standardization in Oklahoma
Executive Summary

What did we conclude?

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

"Banding Together for Patient Safety" 6

Color-coded Wristband
Standardization in Oklahoma
Executive Summary

What did we do?

- OHA reviewed the growing national trend to adopt standardized alert wristband colors.
- In early 2009, the Oklahoma Hospital Association Council on Quality and Patient Safety recommended and the OHA Board approved a statewide initiative supporting these 5 colors for standardization.

"Banding Together for Patient Safety" 7

Color-coded Wristband
Standardization Tool Kit Created for Oklahoma Hospitals

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

"Banding Together for Patient Safety" 8

Color-coded Wristband
Standardization Tool Kit Created for Oklahoma Hospitals

The Tool Kit contents include (cont.):

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

"Banding Together for Patient Safety" 9

Color-coded Wristband
Standardization in Oklahoma
Executive Summary

Our safety as a state and success in this effort will depend on the participation and adoption of each and every hospital in this state.

"Banding Together for Patient Safety" 10

Color-coded Wristband
Standardization in Oklahoma

"Banding Together for Patient Safety" 11

Color-coded Wristband
Standardization in Oklahoma
Do Not Resuscitate

Recommendation: DNR - Purple

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

Calling CODE BLUE!

- *Most hospitals used this term to call a code team. In talking with Oklahoma hospitals, we know many of them use this same term.*
- *If Oklahoma selected the color blue for the DNR wristband, the potential for confusion exists.*
- *"Does blue mean I code or I do not code?"*

"Banding Together for Patient Safety" 12

Color-coded Wristband Standardization in Oklahoma

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?**
   - **"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**

"Banding Together for Patient Safety" 13

Color-coded Wristband Standardization in Oklahoma

Allergy

Recommendation: Allergy - Red

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

Quick Adoption

By adopting red for allergy alert, the standardization for this is easily achieved since a number of Oklahoma hospitals already use red for allergy alert.

"Banding Together for Patient Safety" 14

Color-coded Wristband Standardization in Oklahoma

Allergy

Recommendation - RED for the Allergy Alert

1. **Why Red?**
   - **Many hospitals in Oklahoma 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**

"Banding Together for Patient Safety" 15

Color-coded Wristband Standardization in Oklahoma

Fall Risk

Recommendation: Fall - Yellow

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

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

"Banding Together for Patient Safety" 16

Color-coded Wristband Standardization in Oklahoma

Fall Risk

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 by anyone**

"Banding Together for Patient Safety" 17

Color-coded Wristband Standardization in Oklahoma

Restricted Extremity

- ***Recommendation - Pink for Restricted Extremity***
- **It is recommended that hospitals adopt the color of Pink for the Restricted Extremity Alert designation with the words embossed / written on the wristband or clasp, "Restricted Extremity."**

"Banding Together for Patient Safety" 18

Color-coded Wristband
Standardization in Oklahoma
Restricted Extremity

Recommendation - Pink for Restricted Extremity

1. Why Pink?
   When a patient has this color-coded wristband, it is alerting the health provider that the patient's extremity should be handled with extreme care. This alerts providers to check with the nurse prior to any tests or procedures.
2. Why even use an alert for Restricted Extremity?
   The pink wristband has been used for breast cancer/lymphedema patients to indicate the extremity should not be used for starting an intravenous line or drawing laboratory specimens. Circulation is compromised in a patient with lymphedema and unnecessary invasive procedures should be avoided in the affected extremity. Pink wristbands can be used to indicate any other diagnosis that results in a restricted extremity.

"Banding Together for Patient Safety" 19

Color-coded Wristband
Standardization in Oklahoma
Latex Allergy

Recommendation - Green for Latex Allergy

It is recommended that hospitals adopt the color of GREEN for the latex allergy alert designation with the words embossed/written on the wristband or clasp, "Latex Allergy."

"Banding Together for Patient Safety" 20

Color-coded Wristband
Standardization in Oklahoma
Latex Allergy

Recommendation - Green for Latex Allergy

1. Why Green?
   When a patient has this color-coded wristband, it indicates an allergic reaction to latex. This green wristband will alert the doctors, nurses, and other health care professionals about latex allergies.

"Banding Together for Patient Safety" 21

Color-coded Wristband
Standardization in Oklahoma

"Banding Together for Patient Safety" 22

Color-coded Wristband
Standardization in Oklahoma
Work Plan Documents

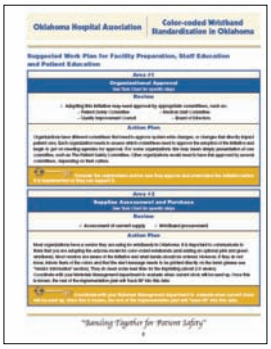
A Suggested Work Plan for Facility Preparation, Staff Education, and Patient Education that includes:

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.

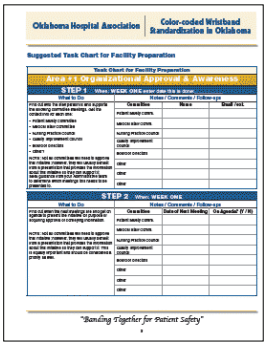
"Banding Together for Patient Safety" 23

Color-coded Wristband
Standardization in Oklahoma
Sample Work Plan Document



"Banding Together for Patient Safety" 24

Color-coded Wristband
Standardization in Oklahoma
Sample Task Chart


Oklahoma Hospital Association | Color-coded Wristband Standardization in Oklahoma

Suggested Task Chart for Facility Preparation

"Banding Together for Patient Safety"

"Banding Together for Patient Safety" 25

Color-coded Wristband
Standardization in Oklahoma

"Banding Together for Patient Safety" 26

Color-coded Wristband
Standardization in Oklahoma
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

"Banding Together for Patient Safety" 27

Color-coded Wristband
Standardization in Oklahoma
Staff Education

Tri-fold Staff education brochure that includes:

1. How this all got started…The Pennsylvania story
2. Why we need to do this in Oklahoma
3. The National Picture
4. What the colors are for: Allergy, Fall Risk, DNR, Latex Allergy and Restricted Extremity
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

"Banding Together for Patient Safety" 28

Color-coded Wristband
Standardization in Oklahoma
Staff Education

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

"Banding Together for Patient Safety" 29

Color-coded Wristband
Standardization in Oklahoma
Staff Education

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

"Banding Together for Patient Safety" 30

Color-coded Wristband
Standardization in Oklahoma
Staff Education

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.**

"Banding Together for Patient Safety" 31

Color-coded Wristband
Standardization in Oklahoma
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 five different color-coded "alert" wristbands that we are going to discuss because they are the most commonly ones used.

~ continued on next slide~

"Banding Together for Patient Safety" 32

Color-coded Wristband
Standardization in Oklahoma
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.

~ continued on next slide~

"Banding Together for Patient Safety" 33

Color-coded Wristband
Standardization in Oklahoma
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.

GREEN means Latex Allergy
The nurse is indicating that the patient has or may have an allergy to latex and latex products which could cause anaphylaxis, a potentially life-threatening condition.

PINK means Restricted Extremity
The nurse is indicating the patient's extremity should be handled with care; other care providers are alerted to check with the nurse prior to any tests or procedures.

"Banding Together for Patient Safety" 34

Color-coded Wristband
Standardization in Oklahoma

"Banding Together for Patient Safety" 35

Color-coded Wristband
Standardization in Oklahoma
Policy and Procedures

- **A template Policy and Procedure 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.**

"Banding Together for Patient Safety" 36

Color-coded Wristband
Standardization in Oklahoma
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 the yellow Lance Armstrong LIVESTRONG 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 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 removal.

Reason provided (if any): _____

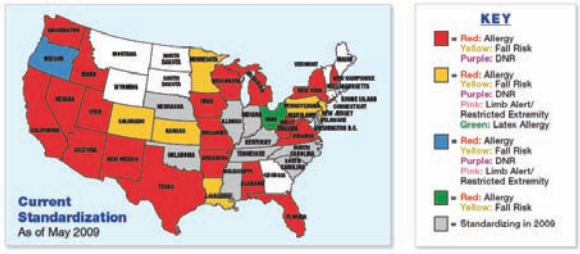
Date / Time	**Signature / Relationship**
Date / Time	**Witness Signature / Job Title**

"Banding Together for Patient Safety" 37

Color-coded Wristband
Standardization in Oklahoma

"Banding Together for Patient Safety" 38

Color-coded Wristband
Standardization in Oklahoma
National Efforts



"Banding Together for Patient Safety" 39

Color-coded Wristband
Standardization in Oklahoma
Resources

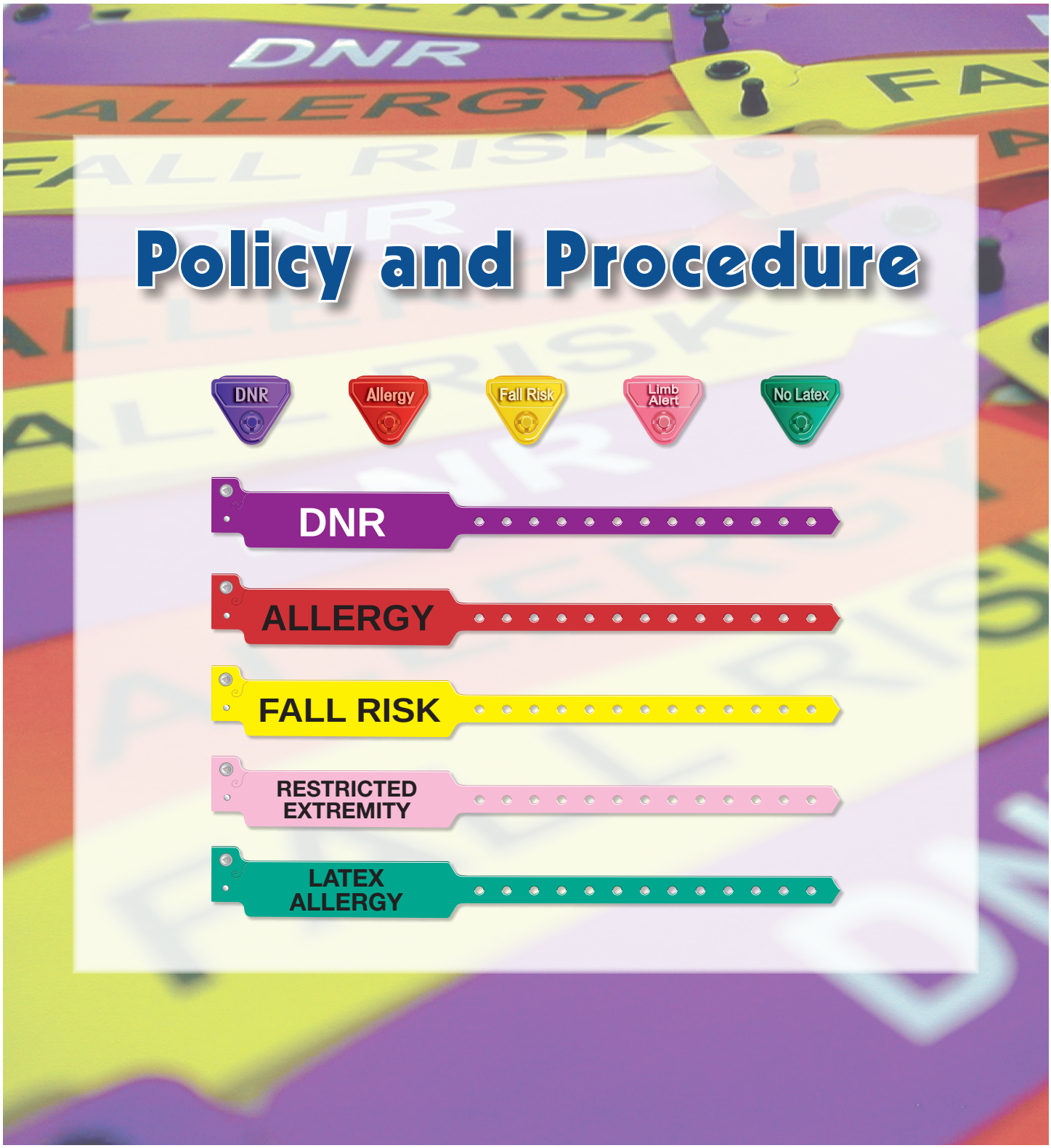
Questions?

Contact LaWanna Halstead, RN, MPH
Oklahoma Hospital Association
Phone number: (405)427-9537
Email: lhalstead@okoha.com

Access an online version patient safety page of the OHA website at:

http://www.okoha.com/wristbandalerttoolkit

"Banding Together for Patient Safety" 40


DNR
ALLERGY
FALL RISK
Policy and Procedure
DNR
Allergy
Fall Risk
Limb Alert
No Latex
DNR
ALLERGY
FALL RISK
RESTRICTED EXTREMITY
LATEX ALLERGY

Policy and Procedure Template

Policy name: Color-coded Wristbands

1. Purpose

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

2. Objective - Color-coded Wristbands

Objectives are:

A. To reduce the risk of potential for confusion associated with the use of color-coded wristbands.

B. To communicate patient safety risks to all health care providers.

C. To include the patient, family members, and significant others in the communication process and promote safe health care.

D. To adopt the following risk reduction strategies:

1. A preprinted written descriptive text is used on the bands clarifying the intent (i.e., "Allergy", "Fall Risk", or "DNR")
2. No handwriting is used on the wristband.
3. Colored wrist bands may only be applied or removed by a nurse or licensed staff person conducting an assessment.
4. If labels, stickers or other visual cues are used in the medical record to communicate risk factors or wristband application, those cues should use the same corresponding color and text to the colored band.
5. Social Cause wristbands, such as the "Live Strong" and other causes, should not be worn in the hospital setting. Staff should have family members take the social cause wristbands home or remove them from the patient and store them with their other personal items. This is to avert confusion with the color-coded wristbands and to enhance patient safety practices.
6. To assist the patient and their family members to be a partner in the care provided and safety measures being used, patient and family education should be conducted regarding:
    a) The meanings of the hospital wristbands and the alert associated with each wristband and
    b) The risks associated with wearing social cause wristbands and why they are asked to remove them.

OHA wishes to acknowledge the Pennsylvania Color of Safety Task Force, which developed the initial policy that is the basis for this document.

3. Definitions

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

Band Color	Communicates
Red	Allergy
Yellow	Fall Risk
Purple	DNR
Pink	Restricted Extremity
Green	Latex Allergy

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

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

5. Color-coded Hospital Bands

During the initial patient assessment, data is collected to evaluate the needs of the patient and a plan of care unique to the individual is initiated. Throughout the course of care, reassessment is ongoing which may uncover additional pertinent medical information, trigger key decision points, or reveal additional risk factors about the patient. It is during the initial and reassessment procedures that risk factors associated with falls, allergies, and DNR status are identified or modified. Because this is an interdisciplinary process, it is important to identify who has responsibility for applying and removing color-coded bands, how this information is documented and how it is communicated. The following procedures have been established to remove uncertainty in these processes:

A. Any patient demonstrating risk factors on initial assessment will have a color-coded wristband placed on the same extremity as the patient ID band by the nurse or licensed professional if the nurse is unavailable. This includes all inpatient, outpatient and emergency department patients.

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

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

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

E. In the event that any color-coded wristband(s) have to be removed for a treatment or procedure, a nurse will remove the bands. Upon completion of the treatment or procedure, new bands will be made, risks reconfirmed, and the bands placed immediately by the nurse.

6. Social Cause Wristbands

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

7. Patient / Family Involvement and Education

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

a) The meanings of the hospital wristbands and the alert associated with each wristband;
b) The risks associated with wearing social cause wristbands and why they are asked to remove them.
c) To notify the nurse whenever a wristband has been removed and not reapplied, or
d) When a new band is applied and they have not been given explanation as to the reason.

Patients and families have available to them a patient / family education brochure (see attached) that explains this information as well.

8. Hand-Off in Care

The nurse will reconfirm color-coded wristbands before invasive procedures, at transfer and during changes in level of care with patient / family, other caregivers, and the patient's chart. Errors are corrected immediately.

Color-coded bands are not removed at discharge. For home discharges, the patient is advised to remove the band at home. For discharges to another facility, the bands are left intact as a safety alert during transfer. Receiving facilities should following their policy and procedure for the banding process.

9. 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 within and acknowledged within that care setting only. The color-coded wristband serves as an alert and does not take the place of an order. Do Not Resuscitate orders must be written and verification of Advanced Directives must occur.

10. Staff Education

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

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

11. Patient Refusal

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

{Facility Name}
{Form Number}

Patient Refusal to Participate in the Wristband Process

Patient Identifier Information

Name _____

PID: _____

DOB: _____

Admitting Physician: _____

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 the yellow Lance Armstrong 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 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 removal.

Reason provided (if any): _____

_____

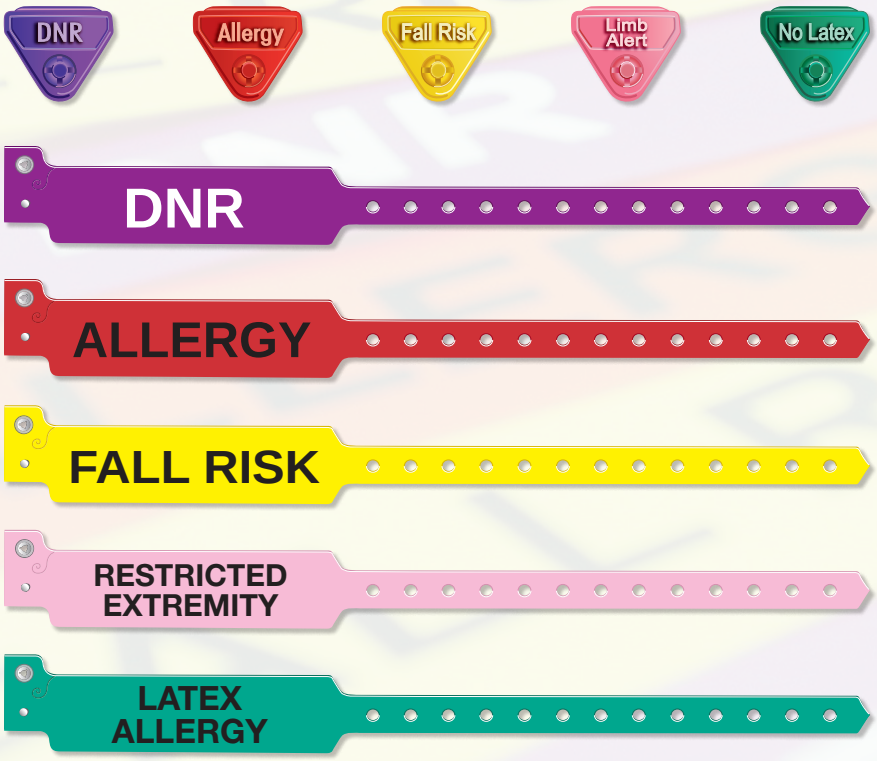
_____ _____

Date/Time **Signature/Relationship**

_____ _____

Date/Time **Witness Signature/Job Title**

Vendor Information

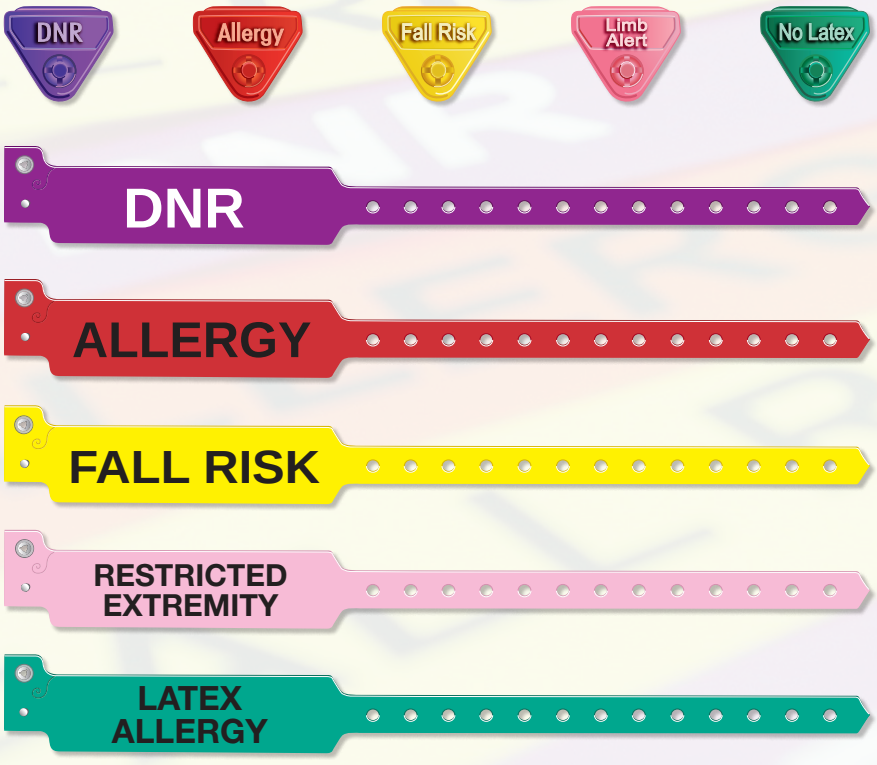


Vendor Information

Most providers belong to a Group Purchasing Organization (GPO) that your Materials Management department works with. In order for the colors of the wristbands to match from facility to facility, the vendor of choice will need the following information:

Wristband Type	Color Specifications	Text Specifications	Font Style and Size
Allergy Wristband	Red — PMS 1788	"ALLERGY" in Black	Arial Bold, 48 pt. All Caps
Fall Risk Wristband	Yellow — PMS 102	"FALL RISK" in Black	Arial Bold, 48 pt. All Caps
DNR Wristband	Purple — PMS 254	"DNR" in White	Arial Bold, 48 pt. All Caps
Restricted Extremity Wristband	Pink — PMS 1905	"RESTRICTED EXTREMITY" in Black	Arial Bold, 28 pt. All Caps
Latex Allergy Wristband	Green — Pantone Green	"LATEX ALLERGY" in Black	Arial Bold, 28 pt. All Caps

Acknowledgements



To access the Tool Kit

The Oklahoma Hospital Association is pleased to share the contents of this tool kit with hospitals in Oklahoma based upon permission from the Arizona Hospital and Healthcare Association and in particular Barb Averyt, program director, Safe and Sound. On behalf of OHA, we want to thank Barb and her workgroup for their passion, excellent tools and willingness to share to make this quality project possible in Oklahoma.

You may access the online information at
http://www.okoha.com/wristbandalerttoolkit

To discuss this project or obtain information, please contact:
LaWanna Halstead, RN, MPH
Vice President/Quality & Clinical Initiatives
Oklahoma Hospital Association
4000 Lincoln Blvd.
Oklahoma City, OK 73105
Office: 405-427-9537
Fax: 405-424-4507
Email: lhalstead@okoha.com

Sponsorship

We also want to thank The St. John Companies, Inc. for their generous sponsorship in this endeavor. If you would like to contact the St. John Companies' representative, please direct your inquiry to:

Karen Joseph
Senior Product Manager – Wristbands / Patient Safety
The St. John Companies, Inc.
25167 Anza Drive
Valencia, CA 91355
Phone: (800) 435-4242 x 448
Fax: (661) 257-2587
Email: kjoseph@stjohninc.com
Web: www.stjohninc.com
www.patientIDexpert.com


St. John Products
DNR
Allergy
Fall Risk
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No Latex
DNR
ALLERGY
FALL RISK
RESTRICTED EXTREMITY
LATEX ALLERGY

Comply with your state color standardization initiative!

Reduce errors and improve patient safety.

Conf-ID-ent™

Patient Identification Wristbands

For a complete selection of patient identification wristbands, including bar codable thermal and laser products, visit us online at www.patientIDexpert.com

The St. John Companies, Inc., an established leader in patient identification and patient safety products for the health care industry, was founded in 1965.

Over the past 50 years, St. John has become one of the leading manufacturers and distributors of Patient Identification, Health Care Labels, Medical Imaging, and Medical Records products to thousands of U.S. hospitals and alternate care facilities.

Our Patient Identification Systems include:

- Admission Wristbands
- Alert Wristbands & Clasps
- Blood ID Wristbands
- Labor & Delivery Wristbands
- Pediatric Wristbands
- Disaster Response Wristbands
- Emergency Room Wristbands

Alerts can be added to the strap of any Conf-ID-ent™ snap closure wristband!

Healthcare facilities use color-coded alerts to indicate special needs, precautions and warnings that can assist caregivers to quickly assess treatment requirements. Because of concerns about lack of standardization for colored alerts, many organizations – both regional and national – have embarked on efforts to create standards for color usage on alerts.

The St. John Companies is at the forefront of the standardization efforts to ensure clear patient safety. St John's products meet the recommendations for standardization in Oklahoma.

Consolidate your admit and alert wristbands "In-A-Snap®!"

Comply with your state color-code standardization initiative "In-A-Snap®"

St. John has teamed up with many hospital associations to help them achieve their color-coded standardization initiatives. By using St. John's proprietary In-A-Snap® alert clasps you also comply with the color-code standardization initiatives currently being adopted in your state and in many states across the USA.

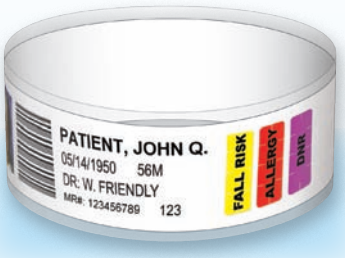
In-A-Snaps are being used in hundreds of hospitals because they:

- Comfortably consolidate your admit and alert wristbands into one
- Eliminate the risk of alert wristbands becoming obscured by other wristbands or patient's gown
- Meet state standardization requirements by combining BOTH colors and words
- Help to eliminate alert wristband mistakes and confusion improving patient safety

Tamper Evident Alert Labels

Consolidate multiple alerts on your laser wristband

- Consolidate multiple alerts on one wristband increasing patient comfort and safety
- Use of standardized colors with words meet hospital association guidelines for color-code standardization
- Synthetic material is durable and long lasting
- Tamper evident destruct marks increase security
- Available in roll or sheet format
- Label size 11/16" x 1/4"
- Cost effective



For a complete selection of patient identification wristbands, including barcodable thermal and laser products, visit us online at www.patientIDexpert.com

ONLINE: www.stjohninc.com • www.patientIDexpert.com • **PHONE:** 800.435.4242
FAX: 800.321.4409 • **EDI:** via GHX • **ADDRESS:** 25167 Anza Drive, Valencia, California 91355

THE St. John COMPANIES™

Your Complete Source for Patient Identification Solutions

Conf-ID-ent™

Patient Identification Wristbands

☑ Admissions ☑ Blood Bank ☑ Emergency Room ☑ Outpatient Surgery ☑ Labor & Delivery

Hundreds of Patient Identification Solutions

Choose from the largest selection of wristband materials, colors, sizes and closures

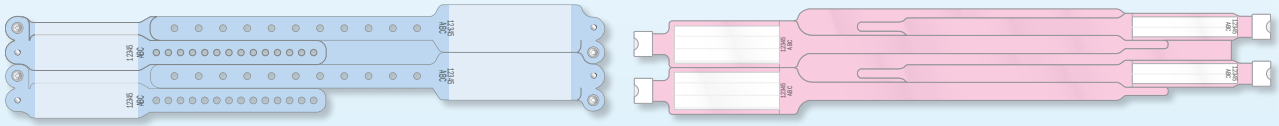
Imprint Wristbands

Insert Wristbands

Write-On Wristbands (Also available with clear protective covering)

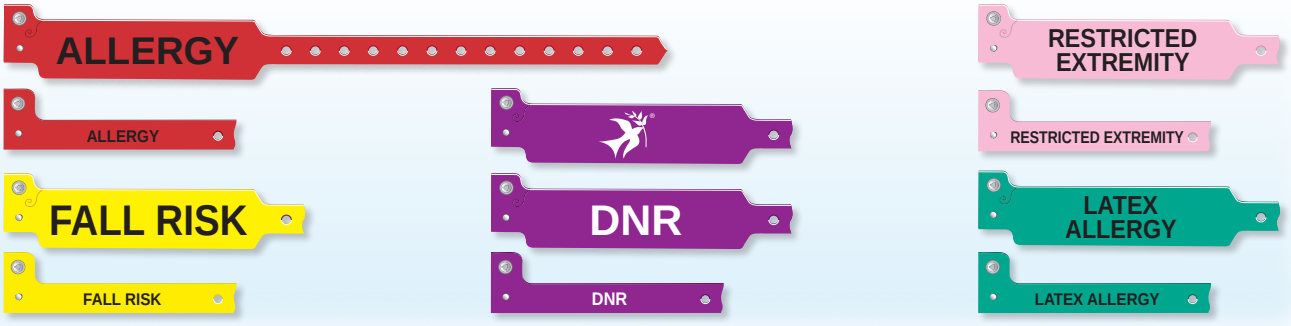
Thermal Wristbands (Available with clasp or adhesive closure)

Mother/Father/Baby Serialized Wristband Sets (Readjustable or snap closure)



Blood Wristbands

Alert Wristbands (Other alert wristbands available)



Our patient safety experts will work with you to determine the best way to ensure clear patient identification and patient safety. If you don't see a solution that meets your needs, we'll be happy to customize one for you.

For a complete selection of patient identification wristbands, visit us online at www.patientIDexpert.com

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FAX: 800.321.4409 • **EDI:** via GHX • **ADDRESS:** 25167 Anza Drive, Valencia, California 91355

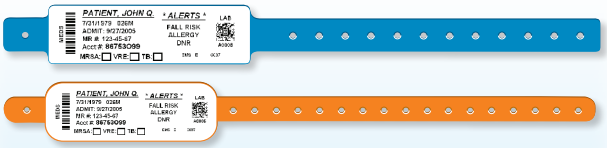
Conf-ID-ent™ ScanRite® Thermal Wristbands

The ScanRite® adhesive and clasp closure wristbands offer low cost and the ease of printing with a thermal printer. A barcode printed by a thermal printer uses heat transfer to create a crisp barcode image resulting in reliable first time read rates. Barcode printers are compact in size with their small footprint. Supports text, linear, 2D and Aztec barcodes.

A thermal wristband is:

- Perfect for barcoding
- Durable – Alcohol, soap and water resistant
- Tamperproof or tamper evident
- Cost effective
- Easy to use
- In-A-Snap® alert clasps can be used with clasp closure wristbands

Clasp Closure

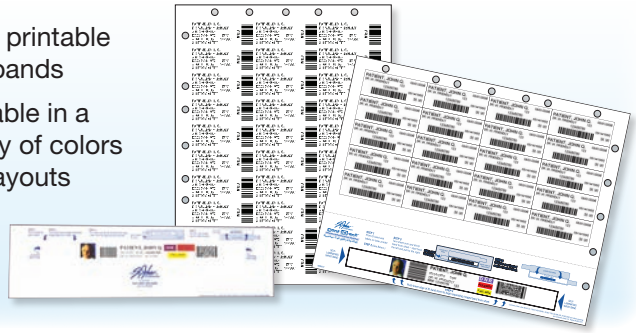


Adhesive Closure

Conf-ID-ent™ Laser Wristbands and Chart Labels

St. John offers the largest variety of laser wristband and chart labels that work with most laser printers. Laser wristbands and chart labels support text, linear, 2D and Aztec barcodes.

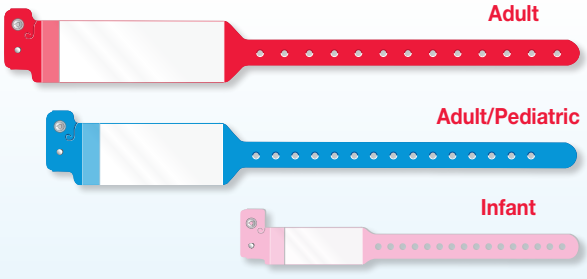
- Clear fold over laminating shield protects the integrity of the patient's information
- Water resistant materials protects patient data
- Optional tamper evident adhesive closure
- Convenient pre-drilled filing holes available
- Laser printable wristbands
- Available in a variety of colors and layouts



Conf-ID-ent™ Laminating Shield Style Wristbands

Laminating shield style wristbands are ideal for barcoding. Featuring a clear anti-glare adhesive shield that provides protection for laser labels by forming a barrier that resists fluid penetration. The anti-glare shield is ideal for barcode scanning providing excellent first time read rates.

- Ideal for barcoding
- Clear anti-glare shield protects patient data
- Tamperproof clasp closure
- Cost-effective
- Easy to use
- Supports text, barcodes and graphics
- Latex and phthalate-free
- In-A-Snap® alert clasps can be used with St. John's clasp closure wristbands



Easy-to-use laminating shield!

Step 1: Fold shield back from wristband.
Step 2: Apply label to the wristband.
Step 3: Peel white liner away from shield.
Step 4: Apply shield over label.

Laminating shield protects patient information.

For a complete selection of patient identification wristbands, visit us online at www.patientIDexpert.com

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