Ohio Bands of Safety

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Colored Wrist Band Implementation Plan for Ohio

Potential Cause for Error

In December 2005, a patient safety advisory was issued from 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 the nurse wanted to alert staff about. Fortunately in this case, another nurse recognized the mistake and the patient was resuscitated.

In light of this incident, Ohio Patient Safety Institute wanted to determine if this was a potential for harm in Ohio. A survey of Ohio Hospitals, Home Health Agencies, Nursing Homes and Ambulatory settings was conducted in November 2006. While there has been wristband incidents in Ohio none identified led to harm. In addition, a physician in the Toledo area collected a sample of thirty (30) different various wristbands used in the four hospitals which he practiced to demonstrate the complicity and difficulty for interpretation when practicing in multiple facilities.

In December 2006, a taskforce consisting of representation from Ohio hospitals, nursing homes, home health agencies, hospice, and ambulatory surgery centers convened to develop statewide recommendations. The taskforce was represented by various levels of the organizations including leadership, physicians, nurses, quality improvement personnel, patient safety officers, risk managers, and educators.

Purpose

A clearly defined and consistently implemented practice for identifying and communicating patient risk or special needs by minimizing the number of bands to the most essential and standardizing the use of color coded wrist bands

Current State of Use of Colored Wrist Bands

As result of the survey it was discovered that a multitude of colors were being used throughout the state of Ohio. A summary of the colors used and the interpretation is outlined in the chart on the next page.

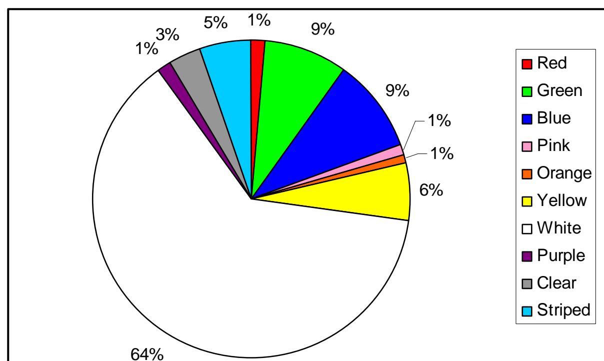
	Red	Green	Blue	Pink	Orange	Yellow	White	Purple	Clear	8 Different Striped	Brown	Cranberry
Allergies												
Blood												
DNR												
Pt ID												
Limited venous access												
Special Needs												
Latex												
No Blood												
Swallow Precautions												
Laterality OR												
Other												

While there were twenty-eight (28) different meanings for the various colors, the taskforce decided to focus on the top six (6) meanings.

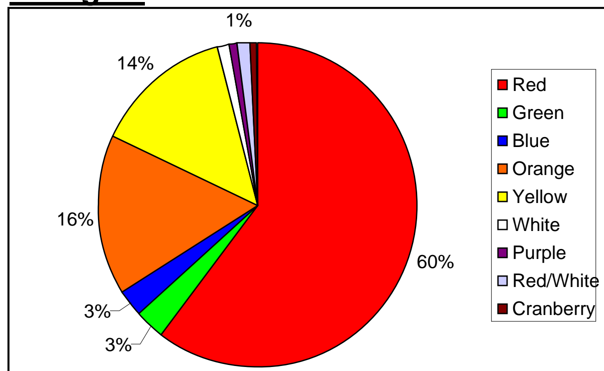
Band Meaning	**Percentage used**
Patient identification	27%
Allergies	19%
DNR (Do Not Resuscitate)	16%
Fall Risk	14%
Blood	9%
Limited Venous Access	5%

Using Human Factors theory, the taskforce decided to limit the number of wristbands recommended to less than five (5). During examination of the top meanings for wristband use the taskforce discovered that for patient identification there were fourteen (14) different colors being used across the state; for allergies nine (9); for DNR twelve (12); for blood eight (8); and for fall risk six (6).

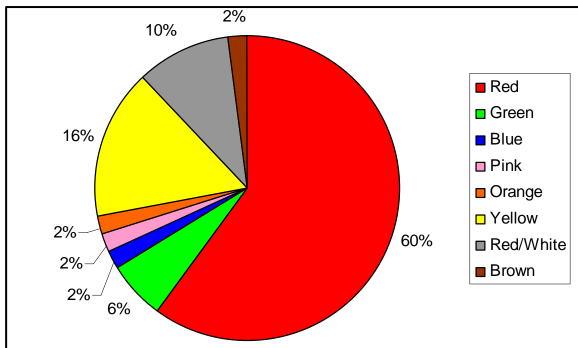
Patient Identification



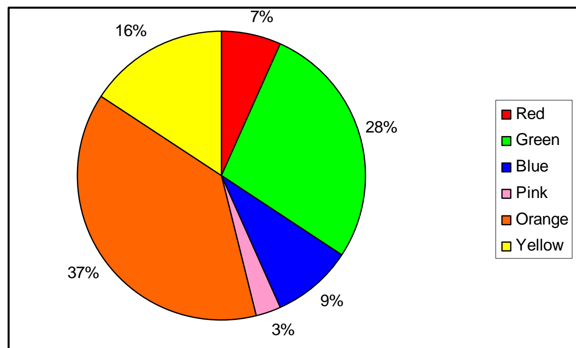
Allergies



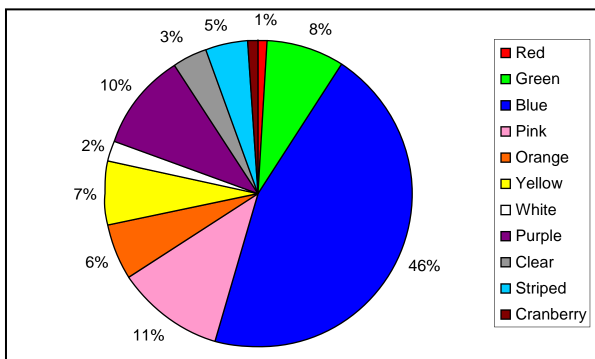
Blood



Fall Risk



Blood



Because the state of Ohio has a state mandated wristband for DNR and there is a group examining the DNR rules for Ohio, the taskforce decided not to make a recommendation for implementation at this time for DNR. However, the taskforce is suggesting to the DNR group to eliminate the use of a wristband for DNR as a DNR wristband dictates a care treatment decision versus an alert like the other wristbands.

Risk Reduction Strategies for Color-Coded Bands

To reduce the risk of potential for confusion associated with the use of color-coded wristbands that communicate patient safety risks, Ohio formed a taskforce of hospitals, nursing homes, home health agencies, hospice and ambulatory surgery centers determined the **goal** should be:

> Reduce reliance or eliminate the use of wrist bands (except patient identification), but in the interim standardize and decrease the number of wrist band colors with embossed message.

The taskforce also adopted the following strategies for color-band alerts:

- Decrease reliance on wrist band use.
- Stress that the colored wrist band is ONLY an alert not a substitute for clinical judgment.
- Encourage use of existing research or seek new research.
- The spectrum of color-coded wrist bands has been limited.
- Avoiding use of shades of the same color to convey different messages can help reduce potential confusion
- To reduce misinterpretation of secondary colors, a preprinted embossed descriptive text is used on the bands clarifying the intent.
- Increase standardization across health care organizations and move to across the nation.
- Except in emergent situations, no handwriting is used on the band.
- Colored wrist bands may only be applied or removed by a nurse.
- If labels or stickers ("stickers") are used in the medical record to communicate risk factors or band application, the stickers will have a corresponding color and text to the colored band.
- Non-healthcare ("community") bands are prohibited to be worn in the hospital setting and are removed or covered by the nurse on admission to avert confusion with the colored-hospital band. Community bands include charity and fashion bands.
- Patient and family education is conducted on risks associated with community bands and in the meanings of the hospital wrist bands that have been applied.

Ohio Recommended Wrist Band Colors

Prior to determining Ohio recommended wristband colors, the taskforce explored what other states were recommending especially surrounding states. Currently Indiana, Kentucky and Michigan have not made recommendations. Below are the recommended colors from patient safety organizations in other states.

	Pennsylvania	W. Virginia (draft)	Colorado & Western Region Alliance for Patient Safety	Arizona
Allergy		**Allergy**	**Allergy**	**Allergy**
Fall Risk		**Fall Risk**	**Fall Risk**	**Fall Risk**
Latex Allergy		None	None	None
DNR		**DNR**	**DNR**	**DNR**
Patient Identification		None	None	None
Limb Alert		None	None	None

Ohio final recommendation was to limit wristband colors to four excluding DNR as it is a state mandated wristband and currently under review. The purpose of a color wristband is to be used as an alert or a warning not for care decisions.

Definitions

The following chart presents the meaning of each color-coded band:

Band Color	Communicates
White/Clear with White insert	**Patient Identification**
Red	**Allergy**
Yellow	**Fall Risk**
Green	**Blood**

General FAQ

Q. Back in the day, we never used wristbands. Why should we consider it now?

A. While there is much discussion regarding the issue of "to band or not to band," a literature review to date has not conclusively identified a better intervention. 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 core staff employed by the healthcare organization. Now an increasing number of healthcare providers are not organization-based staff, so it is imperative that current processes eliminate any potential for mistakes to occur.

As technology permits, the taskforce saw a possibility for the reduction and possible elimination of the use of color wristbands with the exception of the patient identification band in acute or ambulatory settings.

Q, Our hospital is currently only using the patient identification wristband with bar coding. Do we need to go begin to use the color wristbands?

A. No. The ultimate goal of the taskforce was the elimination of all wristbands except the patient identification wristband. You have successfully achieved this goal while maintaining patient safety by using technology.

Q. Our hospital does not use color wristbands but uses stickers, tags or "jewels" on the patient identification wristband. Do we now need to implement the color wristbands?

A. No. The stickers, tags of jewels are acceptable as long as they color schema is coordinated with the recommended colors: red for allergies, yellow for fall risk and green for blood.

Q. What should be done if we have additional color arm bands?

A. The taskforce discourages use of multiple wristband colors for other categories of care, i.e. latex, MRSA, special needs, laterality, etc. Human Factors theory identifies that people remember and use about five things; therefore additional colors may increase risk of error. Remember the wristband is a tool to communicate an alert so evaluate any additional reasons carefully.

Suggested alternative methods for communicating message for other issues:

BAND	IMPLEMENTATION RECOMMENDED
Laterality	Refer to Joint Commission NPSG rationale Mark the site Hand off communication.
Swallow Precautions	Should be part of the plan of care Signage

	Hand off communication.
No Blood (Jehovah Witness)	Place a sticker on chart Should be part of the hand off communication.
Latex allergy	Incorporate on allergy bracelet List on medication sheet Patient education Patient's plan of care Hand off communication.
Limited Venous Access	Signage. Hand-off communication Patient's plan of care Patient education
Special Needs	Patient's plan of care Hand off communication. Signage
Other (pacemaker, ICD, etc.)	Patient's plan of care Hand off communication.

Q. What is an organization to do if use the Broselow color-coding system for Pediatrics?

A. If your facility uses wristbands for pediatric patients that relate to the Broselow color-coding system for pediatric resuscitation carts, consider the potential for confusion between the Broselow bands (which are most likely used in the Emergency Department, Pediatrics and Neonatal Intensive Care) and the other color wristbands your facility uses.

Patient Identification Wristbands

The white or clear with white insert patient identification wristband in all settings are applied in accordance with procedures outlined in organizational policy on patient identification and registration.

FAQs

Q. Why was white or clear selected?

A. White or clear was selected based on survey results that two-thirds of the healthcare organizations in Ohio indicated they were already using white or clear for patient identification. This will decrease the amount of change and cost necessary to implement the statewide recommendation.

Q. Why not use different colors in other organization areas such as emergency department or outpatient?

A. Using different color wristbands for patient identification in other areas of the organization increases the risk of erroneously interpreting the wrong message at a glance, for example if a yellow wrist band color is used for patient identification in the emergency department and then admitted, the patient could be mistaken to be at risk for falls.

Allergy Wristbands

Red Allergy wristbands with the word "Allergy" printed in black are applied in all settings. The actual patient allergies should not be written on the wristband due to legibility and the comprehensiveness of allergy list. The healthcare professional is to refer to the medical record for a comprehensive list of patient allergies.

FAQs

Q. Why was red selected?

A. Red was selected based on survey results that two-thirds of the healthcare organizations in Ohio indicated they were already using the color red. This will decrease the amount of change and cost necessary to implement the statewide recommendation.

Q. Are there other reasons for using red?

A. Research of other industries identified that red has an association that implies extreme concern. The American National Standards Institute (ANSI) has designated certain colors with specific warnings. ANSI uses red to communicate "STOP" or "Danger!" This message holds true for communicating an allergy status. When a caregiver sees red allergy alert they are prompted to "STOP" and double check the medical record if the patient is allergic to a medication, food or treatment they are about to receive.

Q. Should the allergies be written on the wristband?

A. No, the recommendation is that allergies are to be written in the medical record according to the healthcare organization's policy and procedure. Reasons not to write allergies on the wristband include:

1. Legibility may hinder the correct interpretation of the allergy listed.
2. By writing allergies on the wristband one could assume that it is a comprehensive list. However, with limited space on a wristband and some patients have a multitude of allergies; the risk of inadvertently omitting some allergies could lead to confusion or an error.
3. Throughout the stay, allergies may be discovered by other caregivers, this information is typically added to the medical record and not always to the wristband. By having one source of information, the caregiver will know where to add newly discovered allergies as well as have a central source of reference.

Fall Risk Wristbands

It is recommended that healthcare organizations use the color of yellow for fall risk designation with "Fall Risk" embossed on it.

FAQs

Q. Why was yellow selected?

A. Research of other industries indicates that yellow is associated with "Caution!" Think of traffic lights: proceed with caution or stop altogether is the message. The American National Standards Institute (ANSI) has designated certain colors with specific warnings. ANSI uses yellow to communicate "Tripping or Falling hazards." It fits well in healthcare when associated with fall risk. Caregivers would want to know to be on alert and use caution with a person who has a history of falls, dizziness, balance problems, fatigue 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 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 risk of premature death.
4. The total cost of all fall injuries for people age 65 or older in 1994 was $27.3 billion (in current dollars).
5. By 2020, the cost of fall injuries is expected to reach $43.8 billion (in current dollars). Hospital admissions for hip fracture among people over age 65 have steadily increased, from 230,000 admissions in 1988 to 338,000 admissions in 1999.
6. The number of hip fractures is expected to exceed 500,000 by 2040. As the aging population enters the acute care environment, one must consider the risk that is present and do all that is possible to communicate to healthcare workers. For more information regarding falls, go to: http://www.cdc.gov/ncipc/factsheets/fallcost.htm.

Blood Wristbands

It is recommended that healthcare organizations use the color of green for blood designation with the blood product identification on it.

Q. **Why was green selected?**

A. Wristband manufacturers currently have blood wristbands in three colors: red, green and yellow. Seventy percent (70%) of Ohio hospitals use an allergy wristband with red being the primary color used in hospitals in Ohio as well as other states and sixty percent (60%) of Ohio hospitals use a fall risk wristband while only thirty-three percent (33%) of Ohio hospitals use a blood wristband. Since red and yellow are currently used for allergies and fall risk, green was selected to represent blood rather than request a special color which could incur additional cost for a special order.

Q, **If a hospital is not using a separate blood wristband (i.e. using bar coding or other technological methods) must they begin to use one?**

A. No, With the ISBT 128 requirements for labeling blood products many organizations are taking advantage of standardized labeling and converting to technological identification methods for bedside patient identification. This permits a high degree of control over the verification process. The green blood wristband, as with the other color wristbands, is an interim step to improve patient safety until technology is fully integrated into the patient identification band.

Community Bands

Following admission identification, the admitting nurse examines the patient for community (charity or fashion) bands. If community bands are present, the nurse will explain the risks associated with the bands during hospitalization, and the patient will be asked to remove the band(s). If the patient agrees, the nurse removes the band and asks the patient to send it home or store it according to organization policy. If the patient refuses, the nurse will cover the band with medical tape or by other means, and document the refusal in the medical record acknowledging the patient understands the risks associated with the community band.

Color-Coded Hospital Bands

During the initial assessments, data is collected to evaluate the needs of the patient and analyzed to develop a plan of care unique to the individual. Reassessment is ongoing and may be triggered by key decision points, or at intervals specified by the disciplines directly involved in providing patient treatment and/or care.

It is during the initial and reassessment procedures that risk factors associated with falls and allergies 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:

- Any patient demonstrating risk factors on initial assessment will have a colored-band placed on the same extremity as the admission identification band by the nurse.
- The application of the band is documented in the chart by the nurse, per organization policy.
- If stickers are used to document in the record, the stickers must correspond to band color and text.
- Upon application of the color band, the nurse will instruct the patient that the band is not to be removed.
- In the event that any color band or bands have to be removed for the treatment of the patient, the nurse will remove the bands, new bands will be made, risks reconfirmed, and the bands placed on another extremity immediately by the nurse.

Patient Refusal or Incapable

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.
If the patient is incapable, combative, or refuses to wear a color band, the healthcare organization should have an alternative plan defined in the policy and procedure such as:

- A photo identification will be taken and the color alert bands or matching alert stickers affixed to the photo identification. *Hospital policy on obtaining a patient's photo applies*
- A form attached to the patient's transfer records to support hand-off communication.

Patient / Family Involvement and Education

On admission, patients are provided with information on risks associated with wearing community (charity) bands while hospitalized. During assessment procedures, the nurse educates the patient about the risks while explaining why the community band should be removed.

When a color-coded hospital band is applied, the patient and family are educated regarding the band message. Patients are advised to alert the nurse whenever the band is removed and not reapplied, or when a new band is applied and they have not been given explanation as to the reason. Patients and families are advised it is their opportunity and responsibility to participate in preventing errors by wearing the color band, and communicating with caregivers during removal and / or application. The

nurse will periodically reconfirm with the patient and family the meaning of the bands. At discharge, the patient is instructed regarding appropriate removal of bands.

Hand-Off in Care

The nurse will reconfirm color bands 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 and on admission to the receiving facility.

Implementation Plan for Organization

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

Area	Requirement	Action Plan
Organization Approval	Approval by appropriate committee/leadership • Patient Safety Committee • Quality Improvement Committee • Medical Staff • Administration • Board of Directors	Need to assess which groups need to obtain approval and schedule presentations so approval can be obtained in a timely fashion
Equipment Selection and Purchase	• Band Procurement • Kardex labels	Assess current supply. Once known, back fill the rest of the dates on your implementation plan. Upon review of the attached information, organization's purchasing agents arrange band purchases within the terms of their individual contract agreements. (Need 2-3 week lead way for imprinting). Coordinate, as appropriate, chart/white board/care plan/door signage/stickers with same color schema **Responsible: Individual Healthcare Organization Purchasing Agents**
Healthcare Organization Specific Documentation	• Policy adoption • Assessment Revision • Forms revised to meet standards	Color-banding policy will need to be reviewed and approved. Healthcare organizations need to review their respective forms for need of modifications (pt. ed, assessments, etc.) Coordinate policy with Risk Management regarding refusal policy. **Responsible: Individual Healthcare Organization Administrators**
Staff Orientation and Training	• Schedule/ training content	Healthcare staff education will need to be scheduled, completed and documented per respective organization policy.

	• Documentation requirement • Posters	Competency content and format is standardized. The form may be individualized for the organization, approved and distributed to staff education personnel to facilitate staff education. Coordinate with staff education and Human Resource departments Make changes to new employee orientation **Responsible: Individual Healthcare Organization Staff Education**
Patient Education	• Types/Content of material • Documentation requirement	Content of patient education attached. Patient education materials (brochures and posters) may be individualized and distributed. Patient education process and documentation practices will be done in accordance with hospital policy. **Responsible: Individual Organization Patient Education Staff**
Communication Plan	• Develop a communication plan to alert staff, patients and the public	Communicate the "Go Live" date weeks before to staff (use posters, newsletters, communication boards, staff meetings, etc) Schedule education programs for all personnel including medical staff, housekeeping, dietary, ancillary clinical services, etc Prepare tools to help facilitate conversations with patients and families regarding the change i.e. posters, scripts for staff, handouts, etc.
Community Education	• "Charity" educational letter • Publicity on safety issues	Need to support efforts to educate all health care providers, as well as the general public regarding color banding issues/policies via : • Newspaper articles/press release • Letters to community charitable organizations • Communication with health care providers **Responsible: OPSI, Color Wrist band Task Force and Healthcare Organization PR Staff**
Measure of success	• Monitor errors related to patient wristbands • OPSI survey in September 2008	• Per current monitoring system • Internally determine adoption and compliance of recommended color wristbands • OPSI will survey healthcare organizations in September 2008 to determine adoption of state wide color recommendations

Policy and Procedure Template

Policy Name: Color Wristband

1. Purpose

To have a standardized process that identifies and communicates 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

a. To reduce the risk of potential for confusion with the use of color-coded wristbands
b. To communicate patient safety risks to all health care providers as well as the patient, family members and significant others to promote safe healthcare

3. Definitions

The following chart presents the meaning of each color-coded band:

Band Color	Communicates
White/Clear (with White insert)	Patient Identification
Red	Allergy
Yellow	Fall Risk
Green	Blood

4. Identification (ID) bands in admission, pre-registration procedure and/or Emergency Department

The white or clear admission identification band is applied in accordance with procedures outlined in organizational policy on patient identification and registration. These identification bands may be applied by non-clinical staff in accordance with organizational policy. The identification band should remain in place throughout the patient's encounter unless information is updated and replaced according to organizational policy.

5. Color-coded hospital bands

During the initial patient assessment, data is collected to evaluate the needs of the patient and develop a plan of care unique to the individual. Throughout the course of care, re-assessment is ongoing which may uncover additional pertinent medical information, trigger key decision points, or reveal additional risk factors regarding the patient. Fall risk and allergies are identified or modified during the initial and/or re-assessments. Since

patient assessment/re-assessment is an interdisciplinary process, it is important to identify the person responsible for application and removal of the color-coded wristband.

a. Any patient demonstrating risk factors on initial assessment will have a color-coded wristband placed on the same extremity as the patient identification band by the nurse or licensed professional if the nurse is unavailable.
b. The application of the band is documented in the chart by the nurse per organization policy
c. If labels, stickers or other visual cues are used to document in the chart, the visual cues should correspond to band color and text.
d. Upon application of the colored band, the nurse will instruct the patient, family member(s) and significant other(s), if present, the purpose of the band and that the wristband is not to be removed.
e. In event that any color-coded wristband(s) have to be removed for a treatment or procedure, a nurse will remove the band(s). Upon completion of the treatment or procedure, the patient will be reassessed, risk(s) (re)confirmed, and appropriate bands placed immediately by the nurse.

6. Social (community) cause bands

Following the patient identification process, a licensed clinician examines the patient for "social cause" wristbands such as charity bands, cosmetic, etc. If a social cause band(s) are present, the nurse will explain the risks associated with the wristband(s) and request 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 other personal belongings of the patient.

If the patient refuses, the nurse will reinforce the rationale for removal and it is their opportunity to participate in efforts to prevent error and their responsibility as part of the team. The nurse will document in the medical record the patient's refusal and explanation provided to patient and family. The nurse will cover the social cause band with gauze, tape or other material to reduce the risk of confusion with healthcare colored wristband.

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 family be acknowledged as valuable members of the healthcare team. Including them in the process of color-coded wristbands will assure a common understanding of what the bands mean, how care if provided when the bands are worn and their role in correcting any information that contributes to this process. Therefore, during the initial assessment and re-assessment (as appropriate) the nurse should take the opportunity to educate and re-educate the patient and family about:

a. The meaning of the wristband(s) and the alert associated with each band
b. The risks associated with wearing social cause bands and why they are asked to remove the bands
c. To notify the nurse whenever a wristband has been removed and not re-applied or

d. When a new band is applied and they have not been given an explanation as to the reason

8. Hand-off Care

The nurse will re-confirm 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 re-assess the patient and follow their policy and procedure for banding process.

9. Staff education

Staff education regarding color-coded wristband will occur during the new employee orientation process and re-enforced as needed.

*Can be adopted by healthcare organiztion.

Staff Education

____
(Organization name)

COMPETENCY CHECKLIST

Purpose: These are the standards of the technical competencies necessary for performance and/or clinical practice. They supplement continuing education programs and the quality improvement program.

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

Methods to Use:

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

* Supervisor's initials signify competency was met

NAME: **JOB TITLE:**

Patient Color Banding Process	DATE	METHOD USED	SUPERVISORS INITIALS	COMMENTS
• Color Code – Intent of Specific Colors				
• Authority for Application of band				
• Process for Band Confirmation				
• Inter-Dept./Agency Communication re band				
• Need for Re-Application of Band				
• Discharge Instructions for home and /or facility transfer				
• Patient refusal to comply with policy				
• Policy on patient/staff restrictions re "Charity" bands				

SIGNATURES	INITIALS	SIGNATURES	INITIAL

____

EMPLOYEE SIGNATURE DATE

Patient Education Requirement

Point of Service	Content	Documentation Requirement
Introduction	1. Reason for banding	1 Start with a story. Since adults like to know why they should do something. A story gives them the information that makes the request relevant – so they want to comply. Use a relevant story of an occurrence at your organization or the one below. It is a true story from Pennsylvania. “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 a “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, where the 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 nurse identified the mistake and the patient was resuscitated. However, the near miss highlights a potential source of error and the opportunity to improve patient safety by re-evaluating the use of color wristbands. We want to thank and acknowledge this hospital for their transparency and disclosure of this event so it can serve as a wake up call for others potentially in similar situations.”

	2. Follow story with data results	By sharing with staff how Ohio uses wristbands makes the information more relevant and reinforces to them the motivation to standardize colors across the state “A survey was conducted of Ohio Hospitals, Home Health Agencies, Nursing Homes and Ambulatory settings in November 2006. While there were nineteen (19) different colors used throughout Ohio, there were twenty-eight (28) different meanings for the various colors. During examination of the top meanings for wristband use the taskforce discovered that for patient identification there were fourteen (14) different colors being used across the state; for allergies nine (9); for DNR twelve (12); for blood eight (8), and for fall risk six (6). Our risk is apparent!”
	3. Explanation of colors	This initiative is being adopted by healthcare organizations statewide. In addition West Virginia and Pennsylvania have adopted standardized wristband colors similar to Ohio. White/Clear means patient identification in all settings Red means Allergy alert Yellow means Fall Risk Green means Blood DNR – State mandated at this time as white with the Ohio DNR logo – the taskforce is working to eliminate or change the band to be consistent with other states
Admission	4. Band maintenance	Admission assessment and charting by the RN will include: • Patient Risk Identified by the assessment nurse. • Appropriate band(s) applied by the assessment nurse.

		• Initiate banding on admission, changes in condition, or information received during hospital stay • Additional supportive documentation such as required on the MAR, Kardex. • Handout on color banding given to patient, if appropriate. • Patient's cooperation in observing the band's placement and integrity. • Instruction documented per organization's pt. education policy.
	5. Risks associated with "Charity Bands" if the patient is wearing one.	• Documentation that the charity band was removed. • Non-compliance to the policy will require a refusal of consent.
Discharge	1. Instruct the patient and/or patient's family on when the band is to be removed if the patient is being discharged to home.	
	2. For intra-agency transfers, explain to the patient/or family why the band is not going to be removed.	• For intra-facility transfers, documentation regarding risk assessments will be communicated to the subsequent care provider via information on the transfer record. • If the patient has a photo identification form, a photocopy will be attached to the transfer record.
FAQs		Use the attached FAQs to respond to questions and/or reinforce color

		selection
Risk Reduction Strategies	1. Use wristbands with embossed message on it (Allergy/Fall Risk)	• This reinforces the message for new employees, helps interpret meaning in low lights, and clarifies the meaning for those who are color blind • Reduces the chance of confusing colors with alert message • Remind staff that the wristband is a tool but the medical record is the source of truth to verify any discrepancies
	2. Remove any "social cause" (i.e. Live Strong") colored bands	• Be sure to address in organization policy • If patient refuses, cover with bandage/tape
	3. Initiate bands upon admission, changes in condition or information received during stay	
	4. Educate patients and families regarding purpose and meaning of wristbands	• Include family/friends in this process to safe guard the patient • Remind them that the color band is another safeguard to prevent mistakes • Use visual reminders as appropriate, i.e. posters, etc
	5. Coordinate chart/white board/care plan/door signage/stickers with same color schema ducate staff to verify patient color alert wristband on assessment, hand-off of care and facility transfer	

References:
PA-PSRS Supplementary Advisory Vol 2, Sup.2, December 14, 2005
ISMP Alert, Vol 11, Issue 5, "Confusion over meaning of color-coded wristbands," March 9, 2006

Patient Wristband Vendors

Vendor			
PDC (Precision Dynamics Corporation) 13880 Del Sur Street San Fernado, CA 91340 Marilin Miller SE Regional Sales Manager 800-847-0670 x 5150 www.pdccorp.com	Allergy Fall Risk Patient Identification	Multiple choices available Multiple choices available Multiple choices available	Embossed with "Allergy" Embossed with "Fall Risk
EndurID 360 Merrimack St Building 9 Lawrence, MA 01843 Robert Chadwick President 866-3726585 (F) 978-686-9710 www.endurid.com	Allergy Fall Risk Patient Identification	Multiple choices available Multiple choices available Multiple choices available	white laser printable band which can then be color coded with any desired color using Color Laser printers
Posey 5635 Peck road Arcadia, Ca 91006 800-447-6739 Jim Minda Posey District Manager 412-779-6667 minda4@comcast.net	Allergy Fall Risk Patient Identification	Red 6247R Yellow 6247Y	Embossed with "Allergy" Embossed with "Fall Risk"
St John Companies 25167 Anza Drive Valencia, CA 91355 Adam Preisach Marketing Manager 800-435-4242 x245 (F) 661-257-2587 www.stjohninc.com	Allergy Fall Risk Patient Identification	Multiple choices available Multiple choices available Multiple choices available	Embossed with "Allergy" Embossed with "Fall Risk"
Standard Register Standard Register P.O. Box 1167 Dayton, OH 45401-1167 Sherry Bannister Label Product Marketing Manager 937.221.1299 office 800.755.6405	Allergy Fall Risk Patient Identification		Embossed with "Allergy" Embossed with "Fall Risk" Positive identification with barcode identifier

www.standardregister.com			-Specialize in custom wristband solutions to address every hospital's needs -Specialize in customized Training/Education Solutions (Kits, binders, posters, reference cards, brochures, magnets, etc.) to deliver up-to-date materials when and where you need them.

Endorsements

Ohio Patient Safety Institute (OPSI)

Ohio Hospital Association (OHA)

Ohio State Medical Association (OSMA)

Ohio Osteopathic Association (OOA)

Ohio Board of Nursing (OBN)

Ohio Academy of Nursing Homes

Association of Ohio Philanthropic Homes, Housing and Services for the Aging (AOPHA)