"Banding Together for Patient Safety"

Color-coded Wristband Standardization Project in Texas

Implementation Toolkit

"Banding Together for Patient Safety"

TEXAS HOSPITAL ASSOCIATION

Texas Organization of Nurse Executives

Texas A&M Health Science Center
Rural and Community Health Institute

TMF Health Quality Institute

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Foreword

At its Feb. 8, 2008, meeting, the Texas Hospital Association Board of Trustees approved participation in a statewide initiative to standardize wristband colors to alert providers about patients at risk for conditions, such as allergies, falls and do-not-resuscitate orders. This action was taken based on information gathered from a January 2008 survey of members of the Texas Organization of Nurse Executives which found that at least nine different colors/methods are used to designate DNR status and fall risk, and seven different colors/methods designate patients with allergies. With the turnover in nursing positions coupled with the use of registry or traveler RNs, the potential for confusion is obvious and avoidable.

While participation in the initiative is voluntary, hospitals are encouraged to adopt the use of three standard colors of wristbands: purple for DNR, red for allergies and yellow for fall risks. Participation will improve patient safety and enhance the workplace for nurses.

Working with TONE, TMF Health Quality Institute and Texas A&M Health Science Center Rural and Community Health Institute, the Texas Hospital Association is providing this toolkit as a benefit to Texas hospitals. The toolkit also is available online at www.texashospitalsonline.org/wristband.

This toolkit was developed from materials created by the Arizona Hospital and Healthcare Association, and is copyrighted by the Texas Hospital Association. AzHHA granted permission to THA to modify the toolkit to incorporate Texas-specific data and references, to eliminate information not applicable to Texas and to comply with THA style guidelines. Individual hospitals may make copies of this toolkit, as well as specific items in it, for their use in educating hospital staff members about the program. However, the three standard colors – purple for DNR, red for allergies and yellow for fall risk – may not be changed. Any other use of this intellectual property is prohibited without the express written permission of the Texas Hospital Association.

Color-coded Wristband Standardization Project in Texas

Implementation Toolkit

With the leadership of the Texas Hospital Association, Texas Organization of Nurse Executives, TMF Health Quality Institute and Texas A&M Health Science Center Rural and Community Health Institute, Texas hospitals are undertaking an effort voluntarily to improve patient safety by adopting standard wristband colors. While this may require major changes in some facilities, the patient safety benefits of standardizing wristband colors are well-documented. The investment in standard color wristbands and staff education will improve the workplace and provide patients with a safer care environment. Thank you for your facility's participation in this important voluntary initiative!

Table of Contents

Executive Summary and Background
- Executive Summary 2
- Human Factors Considered 4
- Other Communication Strategies 5

Standardized Wristband Colors
- Do-Not-Resuscitate 8
- Allergy Alert 9
- Fall Risk 10
- Emergency Alert Wristbands 11
- Risk-Reduction Strategies 13

Work Plan for Implementation
- Work Plan Guide 16
- Task Charts 18
  - Organizational Approval and Awareness
  - Supplies Assessment and Purchase
  - Hospital-Specific Documentation
  - Staff and Patient Education
- Specifications for Vendors 28

Staff and Patient Education/Materials
- Staff Education Training Tips 30
- Teaching Tools 36
  - PowerPoint® with Speaker Notes 36
  - Sample Posters 37
  - Sample Sign-in Sheet 41
  - Sample Staff Brochure 43
  - Frequently Asked Questions 46
  - Sample Staff Competency Checklist 50
  - Sample Patient Brochure 52
  - Sample Wording for Patient Handbook 57
  - Sample News Release 58

Policy and Procedure
- Sample Policy and Procedure 62
- Sample Patient Refusal Form 67

Post-Implementation Survey 70

Acknowledgements 73

Executive Summary and Background

Executive Summary

Background

- Human Factors
- Other Communication Strategies

Executive Summary

In December 2005, the Pennsylvania Patient Safety Reporting System issued a *Patient Safety Advisory* that received national attention. This advisory highlighted 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 do-not-resuscitate. The source of confusion was a nurse who incorrectly had 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 her intended alert. Fortunately in this case, another nurse recognized the mistake, and the patient was resuscitated.

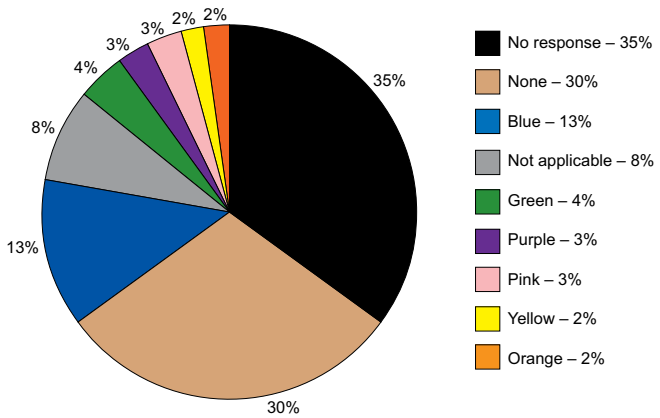
This type of near miss could occur in other institutions. Consider these statistics regarding hospital staffing from the Texas Center for Nursing Workforce Studies' 2008 Texas Hospital Nurse Staffing Survey:

- Texas hospitals reported an average of 11.2 percent nursing positions as vacant;
- the same survey reports the hospital turnover rate for RNs as 16.1 percent; and
- more than 56.4 percent of hospitals reported using temporary staffing agencies to replace sick or absent RNs.

The potential for confusion is obvious, significant and avoidable. As a result of the Pennsylvania *Patient Safety Advisory* reporting that the use of color-coded wristbands creates unnecessary risk, many states began to work toward standardization of color-coded alert wristbands in acute-care hospitals. By fall 2008, more than 25 states had implemented standardized wristband colors for allergies, falls and do-not-resuscitate.

Because of the interest nationally and within Texas, the Texas Hospital Association, Texas Organization of Nurse Executives, TMF Health Quality Institute and Texas A&M Health Science Center Rural and Community Health Institute explored the potential for Texas to join other states in standardizing wristband colors. The organizations wanted to assess whether lack of standardization created a potential for harm in Texas. In January 2008, surveys were sent to TONE members asking questions related to color-coded wristbands. The results were concerning. Nine different colors/methods were being used in Texas to convey DNR; seven different colors/methods conveyed fall risk.

Wristband Colors Used to Designate "Do-Not-Resuscitate" in Texas



Purple – Do-Not-Resuscitate
Red – Allergy
Yellow – Fall Risk

According to a national survey, the following colors of wristbands are used most frequently nationally for DNR, allergy and fall categories.

Because of the consensus reached in more than 25 states and with other states committing to using the same colors, the Texas organizations decided to focus on three condition alerts and to develop an implementation toolkit for hospitals to use to adopt the standardization of color-coded wristbands.

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

- The colors for the alert designation and logic for the colors selected;
- Work plan for implementation;
- Staff education;
- Frequently Asked Questions;
- Patient education with sample brochure, wording for patient handbook and news release;
- Sample policy and procedure; and
- Post implementation survey of staff members.

Background

While there is much discussion regarding whether "to band or not to band," a literature review to date has not identified a better intervention conclusively. Because an increasing number of health care professionals are employed in multiple hospitals simultaneously, it is imperative that current processes take this into consideration. In addition, many facilities supplement local health care professionals with registry and traveler staff members. Although not a substitute for medical record review, an alert wristband on the patient quickly can communicate critical information. An alert wristband provides a visual cue, a reminder to staff of a patient's specific condition or status. This alert reminds the staff member to check the patient's medical record to verify the specific allergy, or confirm the do-not-resuscitate status.

HUMAN FACTORS CONSIDERED

Health care is people-intense, and people make mistakes. With the goal of eliminating errors, hospitals create systems and processes that not only decrease errors but also reduce the opportunity for error-causing situations to arise. Standardizing the colors for specific alert wristbands is an example of an intervention to attempt to prevent errors.

Human error most frequently occurs in stressful, busy, uncommon situations. Health care is delivered in a fast-paced, high-stress environment. Considering the human factors of how we think, how we do things and what we use to accomplish the task enables hospitals to create work processes and systems that include error-prevention mechanisms. Standardizing the colors of alert wristbands across the state – and the nation – helps staff members do their jobs better and safer. Nurses and others no longer have to remember colors or symbols unique to a specific hospital. They can learn a single set of rules that will apply in every Texas hospital.

While standardizing the colors of three wristbands seems simple, several other issues were considered in the development of this program. These include:

Minimal written information. Lengthy information – such as a list of all a patient's allergies – would wrap around the entire wrist. This increases the chance that an important piece of information will be missed, since it might be on the other side of the wristband and was not seen. The wording on the standardized wristbands is short and can be seen easily.

Consistent presentation. The standardized wristbands highlight specific, pertinent information. Too much information can be misread or misinterpreted, especially when someone is in a hurry. The placement of the information is consistent for each wristband.

Easy-to-read. Block letters are used because they are easier to read. Italics are more difficult to read and interpret and are avoided.

Contrast colors. The text contrasts with the background color. Black type on a yellow background is easily read. Black on red also has good contrast and is very readable. The letters on the purple wristband are reversed out in white – again to provide maximum contrast.

Type readability. In general, readability improves with an increase in type size, up to a point. The type font and size of the letters on the wristbands are the same.

OTHER COMMUNICATION STRATEGIES

As your facility embraces this voluntary initiative, you may want to consider other approaches to communicate these and other alerts:

Signage. If signage is used to communicate risks for fall or allergies, or to identify a DNR status, the colors should be the same as the wristbands: purple for DNR, red for allergy and yellow for risk of fall.

Hand-off Communication. According to The Joint Commission, ineffective communication is the most frequently cited category of root causes of sentinel events. Effective communication, which is timely, accurate, complete, unambiguous and understood by the recipient, reduces error and results in improved patient safety. Implementing a standardized approach to "hand-off" communication is one of The Joint Commission's National Patient Safety Goals. The primary objective of a "hand-off" is to provide accurate information about a patient's care, treatment and services, current condition and any recent or anticipated changes. This would include communication about the wristband alert.

HAND-OFF COMMUNICATION

The primary objective of a "hand-off" is to provide accurate information about a patient's care, treatment and services, current condition and any recent or anticipated changes.

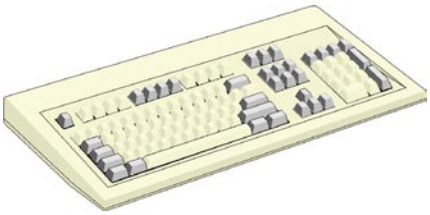
Situation-Background-Assessment-Recommendation (SBAR). The main purpose of the SBAR technique is to improve the effectiveness of communication through standardization of the communication process. Nurses often take more of a narrative and descriptive approach to explaining a situation, while physicians usually want to hear only the headlines of a situation. The SBAR technique closes the gap between these two approaches, allowing communicators to better understand each other. Michael Leonard, M.D., physician coordinator of Clinical Informatics, along with colleagues Doug Bonacum and Suzanne Graham at Kaiser Permanente of Colorado in Evergreen, Colo., developed the SBAR technique. More information on hand-off communication and SBAR can be found at http://www.jcipatientsafety.org/15274/.

Stickers. Placing a sticker on the patient's chart is an alternative method to communicate alerts. If stickers are used, the color scheme should be consistent with the standardized wristband colors: purple for DNR, red for allergy and yellow for fall risk.

Bar Coding Technology. The Food & Drug Administration issued a final rule in 2004 that requires a bar code including the National Drug Code on most prescription drugs and on certain over-the-counter drugs. Bar codes on drugs will help prevent medication errors when used with a bar code scanning system and computerized database. The FDA estimates that the bar code rule will result in

more than 500,000 fewer adverse events over the next 20 years. More information on bar coding can be found at http://www.fda.gov/oc/initiatives/barcode-sadr/fs-barcode.html.

Computer Physician Order Entry (CPOE). This approach requires the physician to enter orders into a computer rather than on paper. Orders are integrated with patient information, including laboratory and prescription data. The order then is checked automatically for potential errors or problems. Specific benefits of CPOE include prompts that warn again the possibility of drug interaction or allergy. More information on CPOE can be found at http://www.leapfroggroup.org/media/file/Leapfrog-Computer_Physician_Order_Entry_Fact_Sheet.pdf.



Medication Reconciliation Form. Many hospitals use medication reconciliation forms to track and reconcile medications upon admission, discharge and transfer. Listing medication allergies and adverse reactions to medications on this form ensures that subsequent providers of care and/or the patient have appropriate information.

Standardized Wristband Colors

Do-Not-Resuscitate

Allergy Alert

Fall Risk

Emergency Alert Wristbands

Risk-Reduction Strategies

Do-Not-Resuscitate

Texas hospitals are encouraged to adopt the color purple for the do-not-resuscitate designation with the letters "DNR" reversed out in white.

While the DNR order must be written by the physician and documented in the chart, when seconds count – as in a code situation – having a visual alert wristband serves an important purpose. This "second" identifier provides instant communication in this type of crisis situation. It is imperative that nurses consult the chart to verify the existence of a do-not-resuscitate order before placing the purple wristband on the patient. And, if the order is rescinded at any point, the wristband must be removed immediately. It is important that family members understand the meaning of the purple wristband, and are encouraged to discuss any questions with the patient and his/her physician.

FAQs

Q. This hospital does not use wristbands for DNRs. Why should the hospital consider adopting this recommendation?

A. Wristbands are used in most Texas hospitals to communicate an alert. Because an increasing number of health care professionals are employed in multiple hospitals simultaneously and many facilities supplement local providers with registry and traveler staff members, confusion can result when the same colors are used for different alerts. A standard-color wristband communicates a quick warning to everyone about this alert. Additionally, it communicates to the patient and the family that the hospital is clear about their end-of-life wishes. By not having a wristband on, the potential for an error is increased.

Q. Why not use blue?

A. Many Texas hospitals call a code by announcing "Code Blue." Having a blue DNR wristband to indicate "no code" easily could create confusion. To avoid creating any second guessing about whether to call a code in this critical moment, blue was not used.

Q. Why not green?

A. Due to color blindness concerns, green was avoided completely. Also, the color green often has a "go ahead" connotation, such as with traffic lights. The possibility of sending "mixed messages" in a critical moment must be avoided.

Q. So, if the hospital adopts the purple DNR wristband, then do staff members 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 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.

Allergy Alert

Texas hospitals are encouraged to adopt the color red for the allergy alert designation with the word "Allergy" embossed/printed on the wristband.

FAQs

Q. Why was red selected?

A. Red was selected due to the January 2008 survey conducted with Texas hospitals that indicated one-half of hospitals already use the color red. Continuing with an established color that already has such overwhelming use makes sense.

Q. Are there any other reasons for using red?

A. Yes. Research of other industries indicates that red has an association that implies extreme concern. The American National Standards Institute has designated certain colors with very specific warnings. ANSI uses red to communicate "stop!" or "danger!" That message should hold true for communicating an allergy status. When a caregiver sees a red allergy alert band, he/she should be prompted to "stop" and double-check if the patient is allergic to the medication, food or treatment about to be delivered.

Q. Should the specific allergies be written on the wristband too?

A. Allergies should be written in the medical record according to your hospital's policy and procedure. Allergies should not be written on the wristband for several reasons:

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

2. Someone could assume that the list of allergies written on the wristband is comprehensive. However, space is limited on a wristband and some patients have 12 or more allergies. Some allergies could be omitted inadvertently – 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 typically is added to the medical record and could fail to be added to a wristband. By having one source of information to reference, such as the medical record, staff members in all disciplines know where to add newly discovered allergies.

Fall Risk

Texas hospitals are encouraged to adopt the color yellow for the fall risk alert designation with the words "Fall Risk" embossed/printed on the wristband.

FAQs

Q. Why was yellow selected?

A. Research of other industries indicates that yellow implies "caution!" Think of traffic lights; a yellow light cautions that the light is about to turn red, and drivers should either clear the intersection quickly or prepare to stop. The American National Standards Institute uses yellow to communicate "tripping or falling hazards." It fits well in health care too when associated with a fall risk. Caregivers need to know to be on alert and use caution with a person who has history of previous falls, dizziness or balance problems, tires easily or is confused about his current surroundings.

Q. Why use an alert band for fall risk?

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

1. More than a third of adults age 65 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, 20-30 percent 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 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 fractures among people over age 65 have increased steadily, 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 the year 2040. As the aging population enters the acute-care environment, one must consider the risk that is present and do everything 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.

Emergency Alert Wristbands

Occasionally hospitals receive patients during an emergency, and they may be wearing wristbands that have special meaning. These should not be removed. The State of Texas has developed a wristband system to track patients evacuated during crisis situations. In addition, the End Stage Renal Disease Network of Texas formed a disaster response coalition to assist dialysis patients during emergency situations. Be sure your staff members are aware of these programs and incorporate these special wristbands into your policy and procedure related to wristbands.

STATE OF TEXAS EVACUATION TRACKING

Radiant RFID's Emergency Management System was selected by the State of Texas to provide for the efficient and organized evacuation of individuals during crisis situations. The unique system provides the ability to locate, identify, move and assist people during emergency evacuations while simultaneously supplying evacuation personnel with the information to assess evacuation status and respond quickly to this data. As people and pets are moved to safety, a **yellow wristband with a printed image of the State Seal of Texas and imbedded RFID technology** is issued. Evacuation personnel efficiently identify and load the evacuee's information, as associated with the RFID wristband, into a system to track individuals throughout the evacuation process. When transported, relocated or upon entering a shelter, evacuees pass through a mobile RFID portal and their location is updated passively and a printed manifest is provided to the shelter host. The system also allows for validation of all registered individuals against other databases for cross referencing. The solution expedites the movement of people, increases security, allows proper allocation of shelter space and resources, and helps families find loved ones. **These wristbands should not be removed.**

DIALYSIS PATIENT TRACKING

In December 2005, the End Stage Renal Disease Network of Texas facilitated the formation of a disaster coalition, the Texas ESRD Emergency Coalition, with numerous renal stakeholders whose purpose is to facilitate the provision of quality care to people with ESRD in the event of an emergency that disrupts the delivery of dialysis and transplant services. The coalition partnered with Emergency Operations Centers and Texas Department of State Health Services leaders to develop a system for identifying dialysis patients during an emergency through the use of **lavender wristbands with core patient identifying information**. A special individual patient network identification number is used on the wristband to identify patients so that any ESRD network could find the patient, even if evacuated to other states. **These wristbands should not be removed.**

Risk-Reduction Strategies

To improve patient safety in the delivery of health care is a goal for every organization. This involves reducing risks for injury or harm whenever possible. By implementing risk-reduction strategies, hospitals 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 efforts to ensure safe practice.

The initial step begins with risk identification. Recognizing trends in adverse events or "the risk thereof" is essential 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 often are underestimated "based on their everyday occurrence." Human factors are often the root cause of such preventable events and frequently are 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 health care facilities.

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 bands mean.**
   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. The text eliminates the chance of confusing alert message colors.

2. **Remove any "social cause" (such as** LIVE**STRONG, breast cancer, etc.) colored wristbands.**
   a. Be sure this is addressed in your hospital policy.
   b. An alternative to removal is covering the band with a bandage or medical tape, but removal is best.

3. **Remove wristbands that have been applied by another facility.**
   a. This should be done during the initial assessment process.
   b. Be sure this is addressed in your hospital policy.
   c. Be aware of exceptions for emergency alert wristbands.

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

5. **Educate patients and family members regarding the purpose and meaning of the wristbands.**
a. Including the family is a safeguard for the staff and the patient.
b. Remind patients and their families that color coding provides another opportunity to prevent errors.
c. Use the Patient/Family Education brochure located in the toolkit.

6. **Coordinate chart/white board/care plan/ door signage information/stickers with the same color coding as the wristbands.**

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

8. **When possible, limit the use of colored wristbands to highlight other categories of care, such as MRSA status.**

9. **Remember, the wristband is a tool to communicate an alert status.**
a. Educate staff to use the patient medical record information (physician order for DNR) as an additional resource for the verification process for allergies, fall risk and advance directives.

10. **If your facility uses pediatric wristbands that correspond to the Broselow color coding system for pediatric resuscitation, take steps to reduce any confusion between these Broselow colors and the colors on the wristbands used elsewhere in the facility.**

Quick Reference Card (camera-ready artwork)

Directions: Make photo copies of the card and cut along outside trim marks.
Fold card in half at dotted lines **before** laminating.

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 by another facility, except for emergency tracking.
4. Initiate banding upon admission, changes in condition or receipt of information during the hospital stay.
5. Educate patients and family members regarding the wristbands.
6. Coordinate chart/white board/care plan/door signage information/stickers with same color coding.
7. Educate staff to verify patient color-coded "alert" wristbands upon assessment and during hand-off of care and facility transfer communication.

Fold

Work Plan for Implementation

Work Plan Guide

Task Charts

Specifications for Vendors

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

#1 – Organizational Approval
See Task Chart for specific steps

To Do

Secure needed approval of this initiative 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 systemwide changes, or changes that directly impact patient care. Assess which committees need to approve the adoption of the initiative and begin to get on meeting agendas for approval. For some organizations, a simple presentation at one committee, such as the Patient Safety Committee, may be all that is required. Other organizations may need to have this approved by several committees, depending on their culture.

KEY: Consider all the stakeholders and be sure they approve and understand the initiative *before* it is implemented so they can support it.

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

To Do

- Assess current supply of wristbands
- Procure new wristbands

Action Plan

Most organizations have a vendor they use for wristbands. It is important to communicate to your vendor that your facility is adopting the standardized color-coded wristbands. Most vendors are aware of this initiative and what bands should be ordered. However, if they do not know, inform them of the colors and the alert messages to be printed directly on the band (please see the “Specifications for Vendors” section). They need some lead time for the imprinting (about two to three weeks).

Coordinate with your Materials Management Department to evaluate when current stock will be depleted. Once this is known, the rest of the implementation plan will “back fill” into this date.

KEY: Coordinate with your Materials Management Department to evaluate when current stock will be depleted. 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

#3 – Hospital-Specific Documentation

To Do

- Adopt policy
- Develop consent forms
- Revise assessment and forms to meet standards

Action Plan

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

Hospitals should review their respective forms for possible modifications (patient education, assessments, etc.) Your facility 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 the Policy & Procedures Committee. A sample has been provided in this toolkit.

KEY: Coordinate with Risk Management staff and individual hospital administrators.

#4 – Staff and Patient Orientation, Education and Training

To Do

- Schedule training and develop content
- Prepare posters and FAQs
- Develop documentation requirement

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.

KEY: Coordinate with Hospital Education staff.

Task Charts

#1 – Organizational Approval and Awareness

STEP 1 – When: WEEK ONE

What to do	Notes – Comments – Follow-ups		
Identify the staff person who supports the following committee meetings. Obtain contact information 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 usually will benefit from a presentation that provides information so they can support it. Seek guidance from your administrative team to determine which meetings should receive the presentations.	**Committee**	**Name**	**E-mail/Ext.**
	Patient Safety Committee		
	Medical Staff Committee		
	Nursing Practice Council		
	Quality Improvement Council		
	Board of Directors		
	Other		
	Other		
	Other		
	Other		

STEP 2 – When: WEEK ONE

What to do	Notes – Comments – Follow-ups		
Find out when meetings are and get on the agenda to present the initiative for purposes of acquiring or conveying information. Note: Not all committees will need to approve this initiative; however, they usually will benefit from a presentation that provides information so they can support it. This is equally important and should be considered a priority as well.	**Committee**	**Meeting Date**	**On agenda? (Yes/No)**
	Patient Safety Committee		
	Medical Staff Committee		
	Nursing Practice Council		
	Quality Improvement Council		
	Board of Directors		
	Other		
	Other		
	Other		
	Other		

#1 – Organizational Approval and Awareness

STEP 3 – When: PENDING APPROVALS

What to do	Notes – Comments – Follow-ups		
	Department	**Information to be conveyed**	**Follow-ups**
After presentations are made and implementation of the program is approved, contact appropriate departments and staff members to initiate action/convey information.	Materials Management	1. Committee approvals obtained. 2. Approval to order wristbands. 3. When will wristbands be available? Take that date and add five to seven more days. That is your “”Go Live” date. (The five to seven additional days 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 _____. 3. OK to start education.	When will education occur?
	Risk Management and/or Quality Improvement Director	1. Wristbands will be arriving in about _____ weeks. 2. “Go Live” date is _____. 3. Confirm that policy and procedure have been approved and start preparation for add-ins to P&P manual.	
	Other departments to consider: Medical Staff, Admitting, Emergency, Peri-Operative, Nursing, Dietary, Laboratory, Radiology, Pharmacy, etc.	1. Wristbands will be arriving in about _____ weeks. 2. “Go Live” date is _____. 3. OK to start education. Coordinate with Education Department for materials, training or information.	

#1 – Organizational Approval and Awareness

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

What to do	Notes – Comments – Follow-ups

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

What to do	Notes – Comments – Follow-ups

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

What to do	Notes – Comments – Follow-ups

#1 – Organizational Approval and Awareness	Date completed / / /

#2 – Supplies Assessment and Purchase

STEP 1 – When: WEEK ONE

What to do	Other Notes/Cues
Brief Materials Manager 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.	Coordinate with the Material s Management contact who will place the order: Name: _____ E-mail: _____ Telephone: _____

STEP 2 – When: WEEK ONE

What to do	Other Notes/Cues
Ask Materials Manager when current supply of wristbands will be depleted. This is based on estimates from typical order patterns and staff usage.	Allergy bands depleted about _____ (ex. mid-January 2009) Fall bands depleted about _____ DNR bands depleted about _____

STEP 3 – When: WEEK ONE

What to do	Other Notes/Cues
Ask Materials Manager to contact wristband vendor and alert to the pending change in supply color. Convey the information in the next column, and check off items as they are communicated to vendors.	**Allergy band:** ☐ Red: PMS 1788 ☐ "ALLERGY" pre-printed on the band in black – 48 pt. Arial Bold, all caps **Fall band:** ☐ Yellow: PMS 102 ☐ "FALL RISK" pre-printed on band in black – 48 pt. Arial Bold, all caps **DNR band:** ☐ Purple: PMS 254 ☐ "DNR" reversed out on band in white – 48 pt. Arial Bold, all caps

STEP 4 – When: WEEK ONE

What to do	Other Notes/Cues
Follow-up with Materials Management in a week and validate that the vendor has been contacted. Complete the information obtained from the Materials Manager in the next column.	Lead time required when ordering wristbands is: Allergy band: _____ weeks Fall band: _____ weeks DNR band: _____ weeks

#2 – Supplies Assessment and Purchase continued

STEP 5 – If any other steps are required, add them here.		
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 Materials Management knows this still is being worked on.	

STEP 6 – If any other steps are required, add them here.		
What to do	**When to do it**	**Other Notes/Cues**

STEP 7 – If any other steps are required, add them here.		
What to do	**When to do it**	**Other Notes/Cues**

STEP 8 – If any other steps are required, add them here.		
What to do	**When to do it**	**Other Notes/Cues**

#3 – Hospital-Specific Documentation

STEP 1 – When: WEEK TWO or THREE

What to do	Other Notes/Cues
Contact Chief Nursing Officer 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 Chief Nursing Officer and clinical directors. It may be helpful or more efficient 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-Operative Assessments/Notes Daily Nursing Documentation Other: _____

STEP 2 – When: WEEK TWO or THREE

What to do	Other Notes/Cues
If current documentation addresses wristband information, review documents to ensure any reference to colors is updated to reflect these changes.	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/Cues
If changes are required to the documentation forms, contact the Forms Committee and pertinent clinical directors and initiate the 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/Cues
Once the 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 coordinated with the arrival of new documents.	

#3 – Hospital-Specific Documentation continued

STEP 5 – When: WEEK FOUR

What to do	Other Notes / 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 to use as a template. Review this sample and adopt its content as appropriate in your organization. ***NOTE**: It is important to compare your current process with the sample P&P and determine what elements to change. The sample P&P is not prescriptive but rather suggestive.*

STEP 6 – When: WEEK FOUR

What to do	Other Notes/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, Labor and Delivery, etc. Contact the directors of these areas to determine if each has a specific policy and procedures or if the hospital's general policy and procedures are followed. Review any needed changes in specific policy and procedures with the respective director.	ED Director, Name/ext.: _____ Unique P&P? No _____ Yes _____ (obtain copy) Peri-Operative Director, Name/ext.: _____ Unique P&P? No _____ Yes _____ (obtain copy) Radiology Director, Name/ext.: _____ Unique P&P? No _____ Yes _____ (obtain copy) Labor and Delivery Director, Name/ext.: _____ Unique P&P? No _____ Yes _____ (obtain copy) "Other" Director, Name/ext.: _____ Unique P&P? No _____ Yes _____ (obtain copy) "Other" Director, Name/ext.: _____ Unique P&P? No _____ Yes _____ (obtain copy)

STEP 7 – When: WEEK FOUR

What to do	Other Notes/Cues
Secure placement of the wristband application changes on the agenda of the P&P Committee. Coordinate this with the departments that have "unique" P&P so all are considered at the same time. Secure approval of changes in policy and procedures.	P&P Committee contact/ext.:_____ Date/Month on P&P Committee agenda _____ Communicate the P&P Committee date to other pertinent directors so the proposed changes are reviewed and agreed upon in advance.

#3 – Hospital-Specific Documentation continued

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

What to do	Other Notes/Cues

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

What to do	Other Notes/Cues

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

What to do	Other Notes/Cues

#4 – Staff and Patient Education

STEP 1 – When: TWO to THREE weeks

What to do	Other Notes/Cues
Become familiar with training content and the tools (FAQs, brochures, posters, etc.)	Review the content of the education section in this toolkit. 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 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/Cues
Discuss the education format with the Education Department and clinical directors to determine if education is going to be managed at the unit-specific level or in a general session where multiple departments are present. Is education going to be facilitated by department-specific directors or the Education Department? It is important to consider all of the stakeholders: physicians, dietary, pharmacy, therapies, radiology, Peri-Operative, ED, L&D, housekeeping, volunteers, students, etc.	**Education Department preferences are:** Unit-specific _____ General session _____ Other (explain): _____ Facilitator preferences: Unit-based_____Education Department_____ **Critical Care Director preferences are:** Unit-specific _____ General session _____ Other (explain): _____ Facilitator preferences: Unit-based_____Education Department_____ **Medical/Surgical Director preferences are:** Unit-specific _____ General session _____ Other (explain): _____ Facilitator preferences: Unit-based_____Education Department_____ **Pharmacy Director preferences are:** Unit-specific _____ General session _____ Other (explain): _____ Facilitator preferences: Unit-based_____Education Department_____

STEP 3 – When: THREE weeks before Staff Education Roll-out

What to do	Other Notes/Cues
Obtain the names of the trainers and send an e-mail advising of an upcoming Train-the-Trainer session. This meeting should be no longer than one hour. Schedule this about one month in advance to accommodate already full schedules.	Whether training occurs at a unit-based level or in a general session, a Train-the-Trainer session should be considered so the education materials and training tips can be reviewed by all and used consistently.

#4 – Staff and Patient Education continued

STEP 4 – When: THREE to FOUR weeks

What to do	Other Notes/Cues
Contact the chair of the "Patient/Community Education" Committee and schedule an appointment to review the patient brochure and wording to add to the hospital's patient handbook distributed upon admission. If necessary, secure a place on the agenda of the next committee meeting to obtain approval for the brochure and handbook wording to be used.	Another component to the education section is patient education. Most organizations have a "Patient/Community Education" Committee that reviews education materials before their use.

STEP 5 – When: TWO weeks before Train-the-Trainer Session

What to do	Other Notes/Cues
Make one copy of the education section of this toolkit for each trainer so each has his/her own set of materials. Include the PowerPoint® presentation. Some organizations may want to put the PowerPoint® on a shared drive, while others may want to burn a copy of the CD.	

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

What to do	Other Notes/Cues
Send an e-mail to all trainers reminding them to make copies of the following handouts for their staff. - Staff education brochure - Patient education brochure - FAQs - Posters announcing the meeting (there are three from which to choose) - Sign-in sheet - Competency checklist (if appropriate)	It may be useful to obtain the actual wristbands to show staff exactly what they look like. Also, try to incorporate some fun into training by using purple, red and yellow "props" or candy – like M&Ms, Skittles, etc.

STEP 7 – When: FOUR weeks before Implementation

What to do	Other Notes/Cues
Contact your hospital's public relations/ marketing staff regarding communication about the color-coded wristband program. Identify target audiences in the hospital and the community and communication tools to reach them.	A sample news release is provided in the education section of this toolkit. It can be used as an article in your hospital's publications.

STEP 8 – If any other step required, add them here

What to do	Other Notes/Cues

Specifications for Vendors

Most hospitals or systems belong to a Group Purchasing Organization that the 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:

Band Type	Color Specifications	Text Specifications	Font Style and Size
Allergy Band	Red – PMS 1788	"ALLERGY" in Black	Arial Bold, 48pt. All Caps
Fall Risk Band	Yellow – PMS 102	"FALL RISK" in Black	Arial Bold, 48pt. All Caps
DNR Band	Purple – PMS 254	"DNR" in White	Arial Bold, 48pt. All Caps

Staff and Patient Education/Materials

- Staff Education Training Tips
  - Model Lesson Plan
  - Teaching Tools
    - PowerPoint with Speaker Notes
    - Posters
    - Sign-in Sheet
    - Sample Staff Brochure
    - Frequently Asked Questions
    - Staff Competency Checklist
    - Sample Patient Brochure and Wording for Patient Handbook
    - Sample News Release

Staff Education Training Tips

INTRODUCTION

The following section regarding staff education has been developed knowing that hospitals may choose to use all or parts of it. The goal is to communicate the changes associated with the use of standardized color-coded alert wristbands to your staff. Hospitals are encouraged to adapt the materials and tools to best meet their specific needs. Make this plan work for your hospital.

The following design objectives were used in creating this section:

- The process to guide staff through the changes with standardized color-coded alert wristbands is simple.
- Materials will equip the instructors to teach about these changes.
- No new materials have to be created by staff; this should be nearly a "turn-key" education event.
- Staff can feel confident that all Texas hospitals are hearing the same message and are following a similar implementation plan. This is important if staff members work at more than one hospital.

Who should be educated and how should this be done?

These are decisions that each organization must make. Education can be broad-based or unit-specific, and it can be as simple or formal as desired. Options include staff meetings, formal education sessions and annual competencies; choose an approach that works for your organization. Information about the standardized color-coded wristband alerts should be part of employee orientation so that new staff members are quickly brought up-to-speed on this initiative.

In determining whom to educate, hospitals should consider the following:

- While nurses ultimately are the people who usually band the patient, the health unit clerks are involved extensively in the system process. By including them in the training, they can better assist the nurses.
- Consider the housekeeping staff. They often are present when a patient is trying to get up or walking to the bathroom. If the housekeeping staff member knows a yellow wristband means "fall risk" and sees a patient trying to get up, he/she can call the nursing staff to alert them and potentially prevent a fall.
- Dietary technicians should be trained also. A red wristband means there is an allergy – and not just to medicines. A patient may have a food allergy, and the red band will alert dietary staff members to check for that and note it in the patient's profile.
- Medical staff members need to be aware of the wristband program. Attending and consulting physicians, intensivists, residents and interns need to know what these colors mean. Involving physicians in the process promotes safe health care for all patients and those providing their care.
- Take time to observe the activities of the day at one of the nurses' stations. During even a 30-minute observation, you probably will "see" and "hear" things that make you remember another stakeholder. Include all stakeholders in your education and training process.

GETTING STARTED

Your staff education process likely will involve some type of presentation. A model lesson plan has been developed; a sample PowerPoint® presentation **www.texashospitalsonline.org/wristbandppt** that follows this outline as well as model teaching tools are provided to facilitate staff education. In addition, a brochure for staff members that contains most of the pertinent information about this initiative is provided for distribution at the conclusion of the presentation. Copy for a pocket card that can be printed and laminated is provided; this is another take-away that reinforces the message and provides an instant reminder for staff members.

MODEL LESSON PLAN

(For use with sample PowerPoint® presentation)

Welcome

Thank participants for their time in attending the session. Build common ground by emphasizing the shared goal of delivering safe patient care. Summarize the goal of the session, which is to prepare to implement the standardized color-coded wristband program. Emphasize that this is a voluntary initiative among hospitals across the state and nation to improve patient safety. Tell the group how the presentation is organized, and then begin.

Start with a story.

Adults want to know "why" they should do something; simply telling them they need to start doing this is not sufficient information to get high levels of compliance. A story gives them information that makes the request relevant – and they will want to comply.

One panel of the brochure tells the true story where a patient was not coded due to confusion over the meaning of the wristband. The error was caught in time to quickly resuscitate the patient, but by telling this story, most staff members will understand how this error could happen to anyone – and they will support the standardization of color-coded wristbands.

Sample story:
In December 2005, the Pennsylvania Patient Safety Reporting System issued a *Patient Safety Advisory* that received national attention. This advisory highlighted 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 who incorrectly had 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 her intended alert. Fortunately, another nurse recognized the mistake, and the patient was resuscitated.

This "near miss" highlights a potential source of error and an opportunity to improve patient safety. This is why the hospital has elected to participate in a national standardization of color-coded wristbands program.

Follow the story with data results.

Sharing how Texas hospitals use wristbands reinforces the potential for errors among staff members, particularly those who work in multiple facilities. The Texas statistics are in the brochure.

Sample statistics:
A survey of Texas hospitals was conducted in January 2008 to evaluate the risk for such an event in this state. The results showed that nine different colors/methods were being used to designate the DNR status with patient wristbands. The risk in Texas is apparent. The answer is this project.

Texas hospitals voluntarily are standardizing the colors of wristbands being used for allergies, fall risk and DNR.

Share the "big picture."

For many individuals, knowing they are part of a bigger and unique situation fosters pride and reinforces motivation to comply. Tell staff how your facility is part of statewide, regional and national efforts to standardize the colors for wristbands used in health care settings.

Sample facts about the program:
Texas standards are the same as those being used in more than 25 other states, and more states are in the process of implementing similar standards. Once standardization is achieved, it means whether you are traveling on vacation to these states or relocating to work in another state, most hospitals will be using the following colors:

- Red means allergy alert.
- Yellow means fall risk.
- Purple means do-not-resuscitate.

Introduce the colors and your hospital-specific program.

Review the three wristband colors and their corresponding meanings. Obtain samples from your vendor to use in your presentation. Other alert wristbands that your organization uses – such as "restricted extremity" or "infection precautions" – may be introduced with this information. Announce the effective date for use of the color-coded wristbands as well as procedures for stocking the unit.

Information to present:
There are three different color-coded "alert" wristbands that are a part of the statewide standardization initiative.

- Red means allergy alert.
- Yellow means fall risk.
- Purple means do-not-resuscitate.

Present the Frequently Asked Questions document.

Research about colors and human association with them 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. At this time, hand out the FAQ sheet to each participant and review it with them. Make this an interactive part of the training, and ask each person attending to take a question (there are 11) and read the answer to the group. 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.

Introduce the risk-reduction strategies.

Review the seven risk reduction strategies associated with color-coded wristbands. Discuss hospital-specific implementation policies/procedures. Examples may help reinforce key points. The "quick reference card" may be printed, laminated and distributed to participants.
(See next page.)

Quick Reference Card (camera-ready artwork)

Directions: Make photo copies of the card and cut along outside trim marks.
Fold card in half at dotted lines **before** laminating.

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 by another facility, except for emergency tracking.
4. Initiate banding upon admission, changes in condition or receipt of information during the hospital stay.
5. Educate patients and family members regarding the wristbands.
6. Coordinate chart/white board/care plan/door signage information/stickers with same color coding.
7. Educate staff to verify patient color-coded "alert" wristbands upon assessment and during hand-off of care and facility transfer communication.

Fold

Introduce hospital policy and procedures.

Review your hospital-specific policy and procedures. Your discussion should address removal of wristbands that may be present upon admission and the exceptions for emergency identification purposes, application of an allergy or fall risk band and removal of wristbands when conditions change. Be sure to address who determines that a wristband is needed, and who applies and removes wristbands and when. Include discharge instructions. A physician's order for do-not-resuscitate must be in the medical record before a DNR wristband is applied.

Include procedures related to documentation in the medical record, including a patient's refusal to wear the wristband if your policy has this provision, and alternatives to removal of "social cause" wristbands, if allowed by your policy.

Review communications procedures, including chart/white board/care plan/door signage information/stickers with same color coding. Be sure to address communication upon assessment and during hand-off of care and facility transfer.

Review your policy and procedure for patient education.

Review patient education information/ materials.

Since how something is said is just as important as what is said, staff members need guidance to optimize communication. Patients and their loved ones are scared, vulnerable and unfamiliar with hospital ways, and the application of a color-coded "alert" wristband may heighten anxiety. Communication should be respectful and simple without being condescending.

The following text is a model "script" that staff members may be instructed to use to deliver consistent information to patients and families. Having a consistent message reinforces the information, which improves patients' and family members' retention. Another benefit of having a consistent message is that patients and families experience a sense of confidence in the health care system since all staff members deliver the same information. The "script" below is taken directly from the staff brochure.

A sample patient education brochure has been created, and may be modified/personalized by your hospital. If your hospital decides to distribute the special information to patients who qualify for a color-coded wristband, be sure to include this fact as part of the training. You may want to distribute copies of the patient brochure after you present the script.

Model script for a staff member talking to a patient or family member:

1. Explain what a color-coded "alert" wristband is.

Color-coded alert wristbands are used in hospitals to quickly communicate a certain health care status or condition that a patient may have. The color-coded wristband is a visual "alert" for all staff members, and helps every staff member provide the best care possible.

2. Explain what the colors mean.

This hospital uses three different color-coded "alert" wristbands, and they are commonly used in Texas as well as in hospitals in multiple other states.

Red means allergy alert. An allergy to anything – food, medicine, latex, dust, grass, pet hair, ANYTHING – should be documented. The red wristband reminds caregivers to check the allergy before delivering food, medicine or other aspects of care. This can be very important to avoid unpleasant reactions.

Yellow means a risk of falls. The hospital wants to prevent falls at all times. Nurses continuously assess patients to determine if they need extra attention to prevent a fall. Sometimes, a person may become weakened due to the illness or because of a recent surgery. When a patient has this color-coded alert wristband, the nurse is indicating that this patient needs to be assisted when walking to avoid a possible fall.

Purple means the physician has written a do-not-resuscitate order. When patients have expressed an end-of-life wish, the hospital and its caregivers want to honor it.

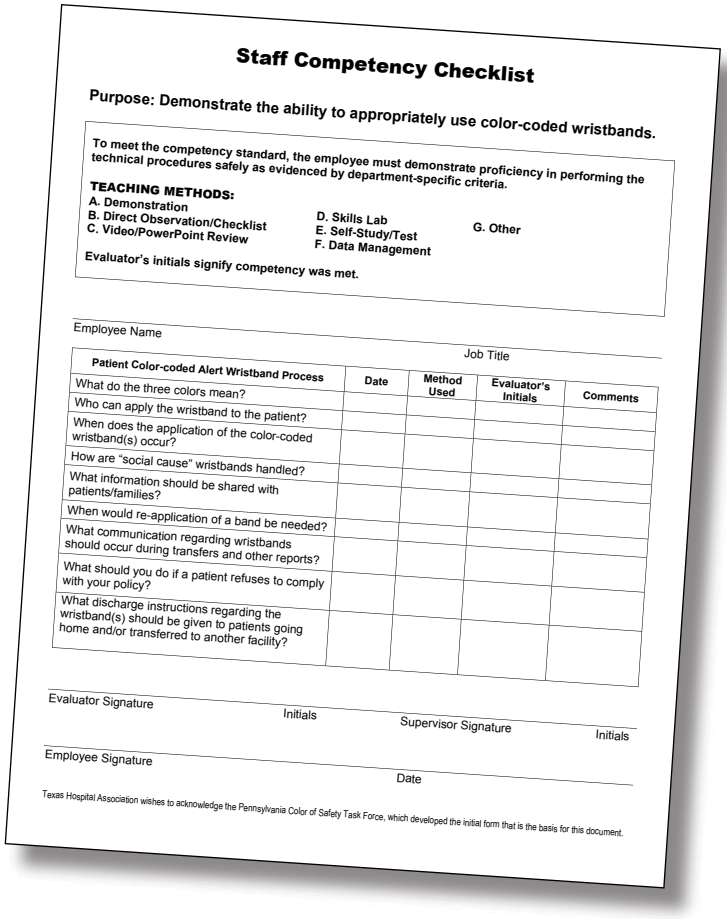
3. Explain when wristbands are applied and removed.

Color-coded wristband alerts are applied when the nurse becomes aware of the condition or status. For example, someone with a medication allergy will receive a red wristband upon initial assessment. A patient may receive a yellow wristband after he has surgery or a particular test that involves sedation. A patient may designate or revoke an end-of-life directive at any time, and the wristband is applied or removed promptly.

Review key points a final time.

These are the items that are listed on the competency checklist, so it is important to clarify that staff members have a good understanding of these items. You should emphasize that knowing this information is critical to performing their jobs every day. if your policies and procedures do not address any of the items on the competency list, then modify it if you plan to use it.

- What do the three colors mean?
- Who can apply the wristband to the patient?
- When does the application of the color-coded wristband(s) occur?
- How are “social cause” wristbands handled?
- What information should be shared with patients /families?
- When would re-application of a band be needed?
- What communication regarding wristbands should occur during transfers and other reports?
- What should you do if a patient refuses to comply with your policy?
- What discharge instructions regarding the wristband(s) should be given to patients going home and /or transferred to another facility?



Staff Competency Checklist

Purpose: Demonstrate the ability to appropriately use color-coded wristbands.

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

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

Evaluator's initials signify competency was met.

Employee Name _____ Job Title _____

Patient Color-coded Alert Wristband Process	Date	Method Used	Evaluator's Initials	Comments
What do the three colors mean?				
Who can apply the wristband to the patient?				
When does the application of the color-coded wristband(s) occur?				
How are “social cause” wristbands handled?				
What information should be shared with patients/families?				
When would re-application of a band be needed?				
What communication regarding wristbands should occur during transfers and other reports?				
What should you do if a patient refuses to comply with your policy?				
What discharge instructions regarding the wristband(s) should be given to patients going home and/or transferred to another facility?				

Evaluator Signature _____ Initials _____ Supervisor Signature _____ Initials _____

Employee Signature _____ Date _____

Texas Hospital Association wishes to acknowledge the Pennsylvania Color of Safety Task Force, which developed the initial form that is the basis for this document.

Teaching Tools

1. PowerPoint® (with speaker notes) (file provided)

This presentation was created to provide alternate teaching methods for the trainer. It can be used in large and small groups. Please check the Texas Hospital Association's Web site periodically as the presentation will be updated as needed. Go to www.texashospitalsonline.org/wristband. The presentation is on the CD-ROM and you may personalize the slides for your facility. This version of the presentation includes "Speaker's Notes" so that you can see the slides and the notes; you can modify the notes or adjust the view to suit your preferences.

Online link to PowerPoint® presentation:
www.texashospitalsonline.org/wristband

Teaching Tools

2. Poster Announcing Training Session Dates/ Times (document provided)

These sample posters may be used to announce the training sessions and the new initiative. Post them in staff lounges, employee locker rooms, staff restrooms and in other places where hospital staff members likely will see them.

20 minutes will tell you what to expect with the new changes

Join us on one of 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:_____

Using the correct colored wristband improves patient safety.

Join us on one of 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:_____

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

Day/Date/Time: _____

Location: _____

Day/Date/Time: _____

Location: _____

Day/Date/Time: _____

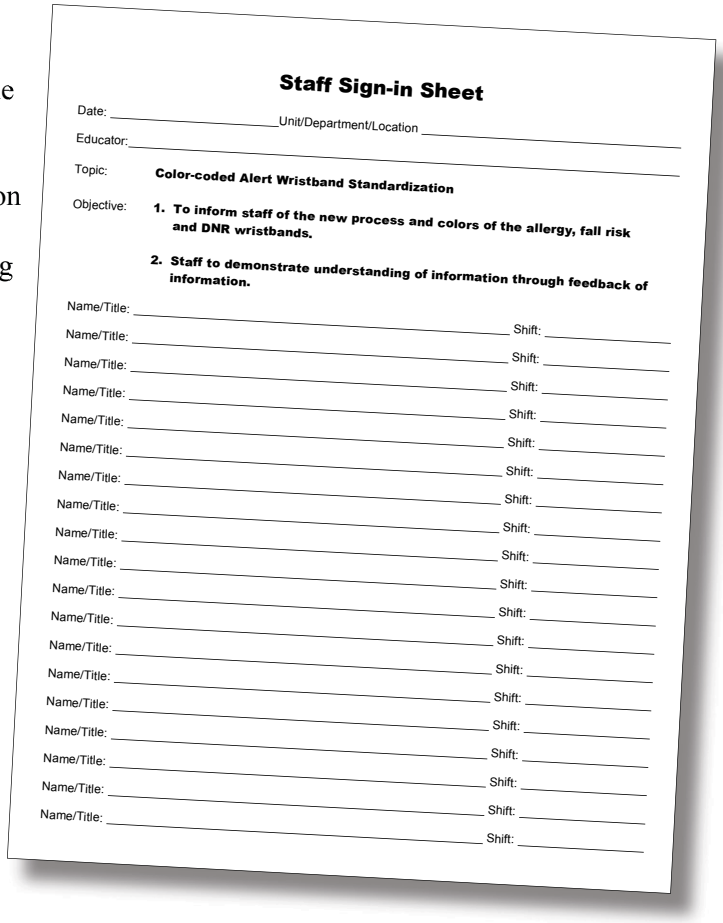
Location: _____

Questions? Contact: _____ ext:_____

Teaching Tools

3. Staff Sign-In Sheet (document provided)

- Copy and use this form so there is a record of all staff who attended the training session.
- This form is available on this CD-ROM. Or, go online to **www.texashospitalsonline.org/wristband**. Find the "Staff Sign-In Sheet" file in the Staff and Patient Education Chapter.
- Keep this sign-in sheet with your staff meeting/training folder. The Joint Commission or 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/Department/Location _____

Educator: _____

Topic: **Color-coded Alert Wristband Standardization**

Objective:
1. **To inform staff of the new process and colors of the allergy, fall risk and DNR wristbands.**
2. **Staff to demonstrate understanding of information through feedback of information.**

Name/Title: _____ Shift: _____

Staff Sign-in Sheet

Date: _____Unit/Department/Location _____

Educator:_____

Topic: **Color-coded Alert Wristband Standardization**

Objective:

1. **To inform staff of the new process and colors of the allergy, fall risk and DNR 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: _____

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Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

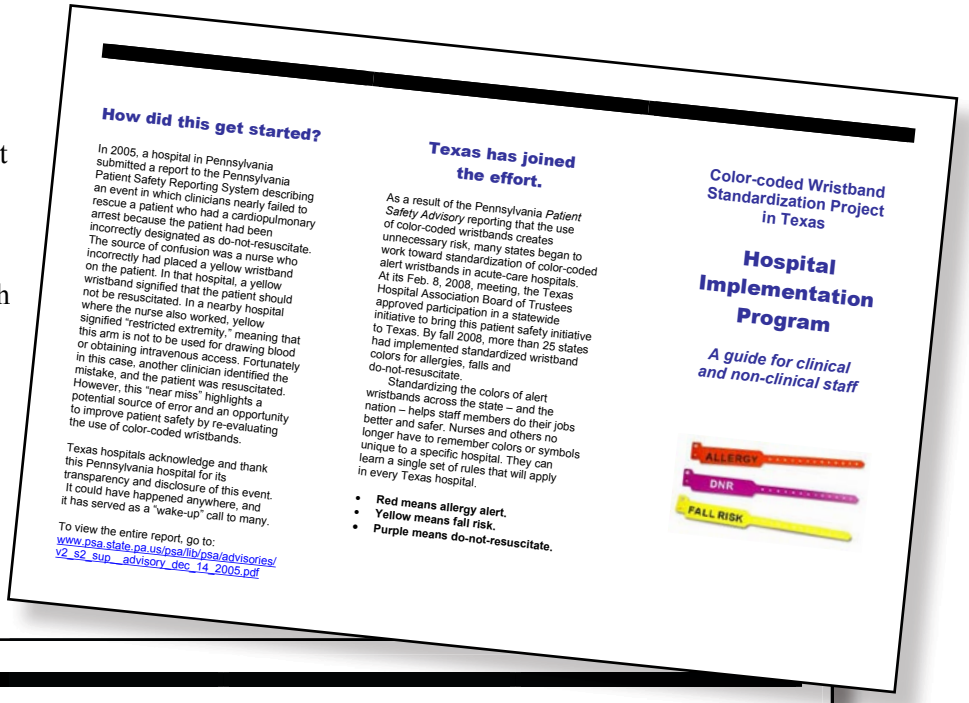
Name/Title: _____ Shift: _____

Name/Title: _____ Shift: _____

Teaching Tools

4. "Staff Education Regarding Color-coded Alert Wristbands" tri-fold brochure (document provided)

This brochure can be used as the main teaching material regarding this initiative. It contains most of the pertinent information staff members need to know to implement the color-coded alert wristband initiative. Although you should announce its availability at the beginning of the training session, the brochure should be distributed at the end of the program. Otherwise, people may start reading the brochure instead of listening to you.



How did this get started?

In 2005, a hospital in Pennsylvania submitted a report to the Pennsylvania Patient Safety Reporting System 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 do-not-resuscitate. The source of confusion was a nurse who incorrectly had placed a yellow wristband on the patient. In that hospital, a yellow wristband 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 intravenous 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.

Texas hospitals acknowledge and thank this Pennsylvania hospital for its transparency and disclosure of this event. It could have happened anywhere, and it has served as a "wake-up" call to many.

To view the entire report, go to: www.psa.state.pa.us/psa/lib/psa/advisories/v2_s2_sup__advisory_dec_14_2005.pdf

Texas has joined the effort.

As a result of the Pennsylvania *Patient Safety Advisory* reporting that the use of color-coded wristbands creates unnecessary risk, many states began to work toward standardization of color-coded alert wristbands in acute-care hospitals. At its Feb. 8, 2008, meeting, the Texas Hospital Association Board of Trustees approved participation in a statewide initiative to bring this patient safety initiative to Texas. By fall 2008, more than 25 states had implemented standardized wristband colors for allergies, falls and do-not-resuscitate.

Standardizing the colors of alert wristbands across the state – and the nation – helps staff members do their jobs better and safer. Nurses and others no longer have to remember colors or symbols unique to a specific hospital. They can learn a single set of rules that will apply in every Texas hospital.

- **Red means allergy alert.**
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Color-coded Wristband Standardization Project in Texas

Hospital Implementation Program

A guide for clinical and non-clinical staff

Color-coded Alert Wristbands: A Statewide Patient Safety Initiative

In January 2008, surveys were sent to Texas Organization of Nurse Executives members asking questions related to color-coded wristbands. The results showed that nine different colors/methods were being used in Texas to convey do-not-resuscitate; seven different colors/methods conveyed fall risk.

The risk was apparent. And the answer is this project.
Confusion can result when the same colors are used for different alerts. A standard-color wristband communicates a quick warning to everyone.

Educating patients and families is important.

How something is said is just as important as *what* is said. It also is important to have a consistent message to help patients/families remember what is said and to instill a sense of confidence in the health care system since all staff members deliver the same information.

The following model "script" should be used to deliver consistent information to patients and families about the standardized color-coded wristband program.

Script

What is a color-coded "alert" wristband?
Color-coded alert wristbands are used in hospitals to quickly communicate a certain health care status or condition that a patient may have. The color-coded wristband is a visual "alert" for all staff members, and helps every staff member provide the best care possible.

What do the colors mean?
This hospital uses three different color-coded "alert" wristbands, and they are commonly used in Texas as well as in hospitals in multiple other states.

Red means allergy alert. Patients should inform caregivers about an allergy to anything – food, medicine, latex, dust, grass, pet hair, etc. The red wristband reminds caregivers to check the allergy before delivering food, medicine or other aspects of care. This can be very important to avoid unpleasant reactions.

Yellow means a risk of falls. The hospital wants to prevent falls at all times. Nurses continuously assess patients to determine if they need extra attention to prevent a fall. Sometimes, a person may become weakened due to the illness or because of a recent surgery. When a patient has this color-coded alert wristband, the nurse is indicating that this patient needs to be assisted when walking to avoid a possible fall.

Purple means the physician has written a do-not-resuscitate order. When patients have expressed an end-of-life wish, the hospital and its caregivers want to honor it.

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 by another facility, except for emergency identification bands.
4. Initiate banding upon admission, changes in condition or receipt of information during the hospital stay.
5. Educate patients and family members regarding the wristbands.
6. Coordinate chart/white board/care plan/door signage information/stickers with same color coding.
7. Educate staff to verify patient color-coded "alert" wristbands upon assessment and during hand-off of care and facility transfer communication.

How did this get started?

In 2005, a hospital in Pennsylvania submitted a report to the Pennsylvania Patient Safety Reporting System 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 do-not-resuscitate. The source of confusion was a nurse who incorrectly had placed a yellow wristband on the patient. In that hospital, a yellow wristband 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 intravenous 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.

Texas hospitals acknowledge and thank this Pennsylvania hospital for its transparency and disclosure of this event. It could have happened anywhere, and it has served as a "wake-up" call to many.

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Teaching Tools

5. Frequently Asked Questions Handout for Staff (document provided)

This FAQ may be used as a handout during staff training sessions. You also may want to post it in staff areas as well.

Frequently Asked Questions

1. The hospital has never used wristbands. Why should we consider it now?

A. While there is much discussion about whether "to band or not to band," a literature review to date has not conclusively identified a better intervention. Because an increasing number of health care professionals are employed in multiple hospitals simultaneously, it is imperative that current processes take this into consideration. In addition, many facilities supplement local health care professionals with registry and traveler staff members. Although not a substitute for medical record review, an alert wristband on the patient quickly can communicate critical information.

2. This hospital does not use wristbands for DNRs. Why should we consider adopting this?

A. Wristbands are used in most Texas hospitals to communicate an alert. Because an increasing number of health care professionals work in multiple hospitals simultaneously and many facilities supplement local providers with registry and traveler staff members, confusion can result when the same colors are used for different alerts. A standard-color wristband communicates a quick warning to everyone. The DNR wristband also communicates to the patient and family that the hospital is clear about their end-of-life wishes. By not using the DNR wristband, a code could be called inappropriately and create serious consequences.

3. Why not use blue for DNR?

Many Texas hospitals call a code by announcing "Code Blue." Having a blue DNR wristband to indicate "no code" easily could create confusion. To avoid creating any second guessing about whether to call a code in this critical moment, blue was not used.

4. Why didn't you select green for DNR?

A. Due to color blindness concerns, green was avoided completely. Also, the color green often has a "go ahead" connotation, such as with traffic lights. The possibility of sending "mixed messages" in a critical moment must be avoided.

5. So, if the hospital adopts the purple DNR wristband, then do staff members 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 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.

Frequently Asked Questions

6. Why was red selected for allergies?

A. Red was selected due to the January 2008 survey conducted with Texas hospitals that indicated one-half of hospitals already use the color red. Continuing with an established color that already has such overwhelming use makes sense.

7. Are there any other reasons for using red for allergies?

A. Research of other industries indicates that red has an association that implies extreme concern. The American National Standards Institute has designated certain colors with very specific warnings. ANSI uses red to communicate "stop!" or "danger!" That message should hold true for communicating an allergy status. When a caregiver sees a red allergy alert band, he/she should be prompted to "stop" and double-check if the patient is allergic to the medication, food or treatment about to be delivered.

8. Do we write the allergies on the wristband too?

A. No. Allergies should be written in the medical record according to your hospital's policy and procedure. Allergies should not be written on the wristband for several reasons:

1. Legibility may hinder the correct interpretation of the allergy listed.
2. Someone could assume that the list of allergies written on the wristband is comprehensive. However, space is limited on a wristband and some patients have 12 or more allergies. Some allergies could be omitted inadvertently – 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 typically is added to the medical record and could fail to be added to a wristband. By having one source of information to reference, such as the medical record, staff members in all disciplines know where to add newly discovered allergies.

9. Why did you select yellow for fall risk?

A. Research of other industries indicates that yellow implies "caution!" Think of traffic lights; a yellow light cautions that the light is about to turn red, and drivers should either clear the intersection quickly or prepare to stop. The American National Standards Institute uses yellow to communicate "tripping or falling hazards." It fits well in health care too when associated with a fall risk. Caregivers need to know to be on alert and use caution with a person who has history of previous falls, dizziness or balance problems, tires easily or is confused about his current surroundings.

Frequently Asked Questions

10. Why even use an alert band for fall risk?

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

1. More than a third of adults age 65 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, 20-30 percent 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 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 fractures among people over age 65 have increased steadily, 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 the year 2040. As the aging population enters the acute-care environment, one must consider the risk that is present and do everything possible to communicate that to hospital staff. For more information about falls and related statistics, go to: www.cdc.gov/ncipc/factsheets/fallcost.htm

11. Who decided on these colors?

A. The Texas project is modeled after the original work done by the Arizona Hospital and Healthcare Association and the experiences of other states that have adopted standardized colors for patient alert wristbands. The consensus of the Texas Hospital Association, Texas Organization of Nurse Executives, TMF Health Quality Institute and Texas A&M Health Science Center Rural and Community Health Institute was to use the three colors adopted by all of the states that have implemented standardized colors.

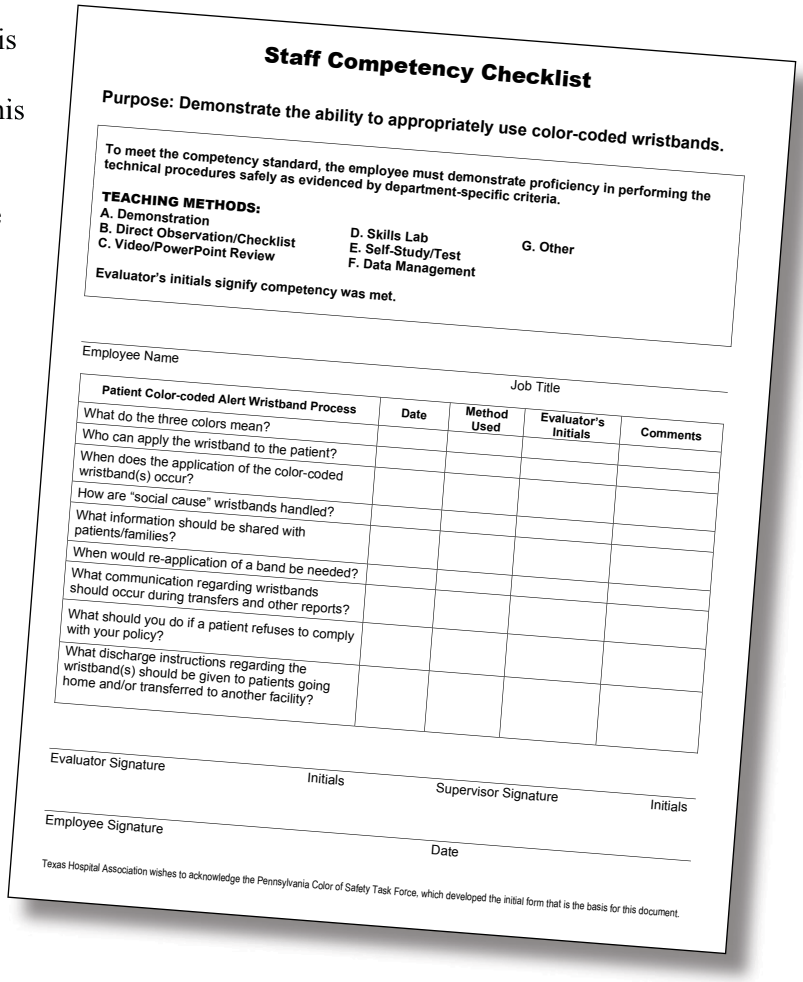
For questions or comments regarding this project, please contact the Texas Hospital Association:

Starr West
Senior Director, Policy Analysis
Texas Hospital Association
1108 Lavaca, Austin, TX 78701
Phone: 512/465-1042
Email: swest@tha.org

Teaching Tools

6. Staff competency checklist (document provided)

Some organizations will opt to use this form to document competency after completion of the training session. This form also serves as a great checklist for the trainer to ensure that all of the important elements in the training are covered.



Staff Competency Checklist

Purpose: Demonstrate the ability to appropriately use color-coded wristbands.

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

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

Evaluator's initials signify competency was met.

Employee Name _____ Job Title _____

Patient Color-coded Alert Wristband Process	Date	Method Used	Evaluator's Initials	Comments
What do the three colors mean?				
Who can apply the wristband to the patient?				
When does the application of the color-coded wristband(s) occur?				
How are "social cause" wristbands handled?				
What information should be shared with patients/families?				
When would re-application of a band be needed?				
What communication regarding wristbands should occur during transfers and other reports?				
What should you do if a patient refuses to comply with your policy?				
What discharge instructions regarding the wristband(s) should be given to patients going home and/or transferred to another facility?				

Evaluator Signature _____ Initials _____ Supervisor Signature _____ Initials _____

Employee Signature _____ Date _____

Texas Hospital Association wishes to acknowledge the Pennsylvania Color of Safety Task Force, which developed the initial form that is the basis for this document.

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Evaluator Signature Initials Supervisor Signature Initials

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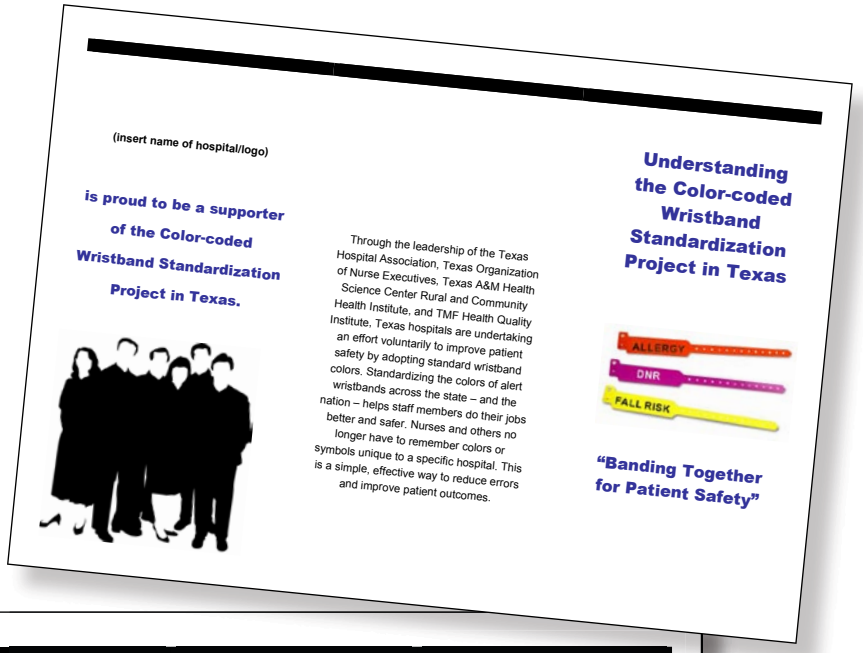
Teaching Tools

7. "Patient Safety: Understanding What Your Color-coded 'Alert' Wristband Means" tri-fold brochure (English and Spanish documents provided)

This sample brochure for patients and family members may be personalized and distributed to help them understand what the wristband colors mean and reinforce verbal information provided when an alert wristband is applied. You should consider distributing the brochure to all patients, regardless of whether they need a color-coded wristband, because it may stimulate the sharing of new information. 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 brochure and bring up the food allergy. This new information can be recorded and a wristband applied, eliminating a potential risk.



(insert name of hospital/logo)

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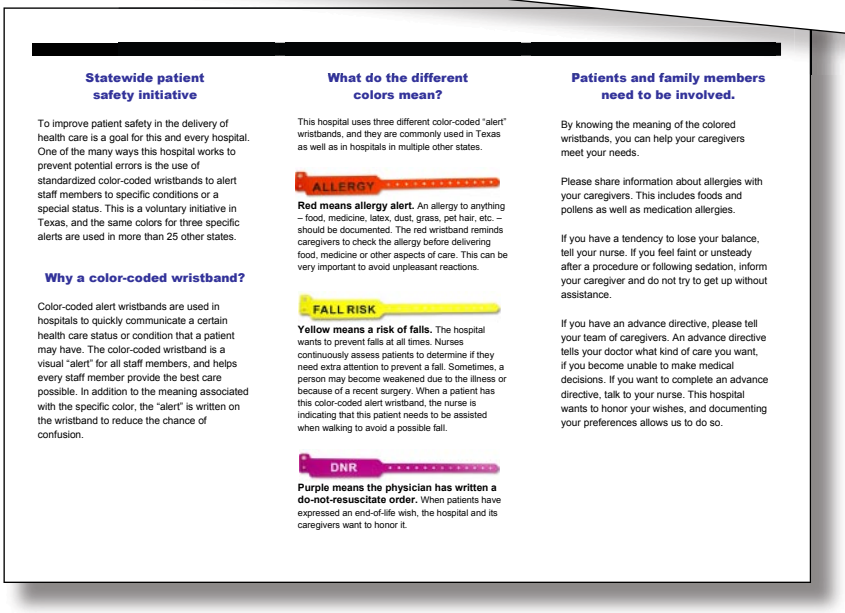
Through the leadership of the Texas Hospital Association, Texas Organization of Nurse Executives, Texas A&M Health Science Center Rural and Community Health Institute, and TMF Health Quality Institute, Texas hospitals are undertaking an effort voluntarily to improve patient safety by adopting standard wristband colors. Standardizing the colors of alert wristbands across the state – and the nation – helps staff members do their jobs better and safer. Nurses and others no longer have to remember colors or symbols unique to a specific hospital. This is a simple, effective way to reduce errors and improve patient outcomes.

Understanding the Color-coded Wristband Standardization Project in Texas

ALLERGY
DNR
FALL RISK

"Banding Together for Patient Safety"



Statewide patient safety initiative

To improve patient safety in the delivery of health care is a goal for this and every hospital. One of the many ways this hospital works to prevent potential errors is the use of standardized color-coded wristbands to alert staff members to specific conditions or a special status. This is a voluntary initiative in Texas, and the same colors for three specific alerts are used in more than 25 other states.

Why a color-coded wristband?

Color-coded alert wristbands are used in hospitals to quickly communicate a certain health care status or condition that a patient may have. The color-coded wristband is a visual "alert" for all staff members, and helps every staff member provide the best care possible. In addition to the meaning associated with the specific color, the "alert" is written on the wristband to reduce the chance of confusion.

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DNR

Purple means the physician has written a do-not-resuscitate order. When patients have expressed an end-of-life wish, the hospital and its caregivers want to honor it.

Patients and family members need to be involved.

By knowing the meaning of the colored wristbands, you can help your caregivers meet your needs.

Please share information about allergies with your caregivers. This includes foods and pollens as well as medication allergies.

If you have a tendency to lose your balance, tell your nurse. If you feel faint or unsteady after a procedure or following sedation, inform your caregiver and do not try to get up without assistance.

If you have an advance directive, please tell your team of caregivers. An advance directive tells your doctor what kind of care you want, if you become unable to make medical decisions. If you want to complete an advance directive, talk to your nurse. This hospital wants to honor your wishes, and documenting your preferences allows us to do so.

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está orgulloso de apoyar la Iniciativa para la implementación de pulseras codificadas por colores estandarizados para la seguridad del paciente de Texas.

Siguiendo el liderazgo del Texas Hospital Association, Texas Organization of Nurse Executives, Texas A&M Health Science Center Rural and Community Health Institute y TMF Health Quality Institute, los hospitales de Texas han asumido el compromiso voluntario de mejorar la seguridad del paciente a través de la adopción de pulseras de colores estandarizados. La estandarización de los colores de las pulseras de alerta en el estado, y en el país, ayuda a los integrantes del personal a mejorar y hacer más seguras sus tareas. Los enfermeros y demás personas ya no van a tener que recordar colores o símbolos que son exclusivos de un hospital en particular. Esta es una manera sencilla y efectiva de reducir errores y mejorar los resultados del paciente.

Comprender la Iniciativa para la implementación de pulseras codificadas por colores estandarizados para la seguridad del paciente

Iniciativa estatal para la seguridad del paciente

Mejorar la seguridad del paciente al brindar atención médica es el objetivo de este y de todos los hospitales. Uno de los diversos métodos utilizados por este hospital para evitar posibles errores es el uso de pulseras codificadas por colores estandarizados a fin de informar a los integrantes del personal acerca de afecciones específicas o algún estado en particular. Esta es una iniciativa voluntaria en Texas, y se utilizan los mismos colores para tres alertas específicas en más de 18 estados.

¿Por qué utilizar pulseras codificadas por colores?

Los hospitales utilizan las pulseras de alerta codificadas por colores para informar rápidamente una afección o un estado relacionado con la atención de la salud que pueda presentar un paciente. La pulsera codificada por colores es un "alerta" visual para todos los integrantes del personal, y les ayuda a brindar la mejor atención posible. Además del significado asociado con el color específico, se escribe el "alerta" en la pulsera a fin de reducir la posibilidad de que existan confusiones.

¿Qué significan los distintos colores?

Este hospital utiliza tres pulseras de "alerta" codificadas por colores diferentes, las que, a su vez, son utilizadas comúnmente en Texas, así como en muchos otros estados.

Rojo significa alerta de alergia. Las alergias, ya sea a alimentos, medicamentos, látex, polvo, césped, pelo de animal, etc., deben registrarse. La pulsera roja recuerda a las personas encargadas de la atención de los pacientes que deben controlar la alergia antes de proveer alimentos, medicamentos u otros aspectos de la atención. Esto es muy importante a fin de evitar reacciones desagradables.

Amarillo significa riesgo de sufrir caídas. El hospital desea prevenir las caídas en todo momento. Los enfermeros continuamente evalúan a los pacientes para determinar si necesitan atención adicional y, de este modo, prevenir una caída. A veces, un paciente puede debilitarse debido a la enfermedad misma o a una cirugía reciente. Cuando un paciente lleva esta pulsera de alerta codificada por colores, el enfermero está mostrando que este paciente necesita ayuda al caminar para evitar una posible caída.

Púrpura significa que el médico otorgó una orden de no reanimar. Cuando los pacientes han expresado un deseo de última voluntad, el hospital y las personas encargadas de la atención de los pacientes quieren cumplírselo.

Los pacientes y familiares deben participar.

Con saber el significado de las pulseras de color, usted puede ayudar a las personas encargadas de la atención de los pacientes a que satisfagan sus necesidades.

Comparta información sobre sus alergias con las personas que cuidan de usted. Esto incluye alergias a alimentos, al polen y a medicamentos.

Si tiene tendencia a perder el equilibrio, infórmeselo a su enfermero. Si se marea o siente que pierde el equilibrio luego de un procedimiento o la administración de sedante, infórmeselo a la persona que cuida de usted y no trate de levantarse sin ayuda.

Si tiene una directiva anticipada, infórmeselo al equipo de personas encargadas de la atención de los pacientes. La directiva anticipada informa a su médico el tipo de atención que desea tener en caso de que, en el futuro, se vea imposibilitado de tomar decisiones médicas. Si desea completar una directiva anticipada, hable con su enfermero. Este hospital quiere cumplir sus deseos, y el registro de sus preferencias nos permite hacerlo.

Teaching Tools

8. Wording for patient handbook.

In addition to distributing a specific brochure to highlight the color-coded "alert" wristband program, your hospital may want to include information in the general patient handbook distributed upon admission.

Sample patient handbook wording:

ABC Hospital is a voluntary participant in a multi-state patient safety initiative that uses standardized color-coded wristbands. Hospitals across Texas and in more than 25 other states have adopted three standard colors to alert staff to specific conditions. Red indicates an allergy; yellow signifies a fall risk; and purple reflects a patient's do-not-resuscitate status. If the nurse assesses you need one or more of these wristbands – either upon admission or at any time during your stay – you will receive information about the type of alert and be asked to wear the wristband. To avoid confusion, the hospital requests that patients remove any "social cause" wristbands. More information is available from your nurse. Our goal is to make your care as safe as possible, and these visual cues help alert all staff members to these specific conditions. Thank you for your cooperation in this important patient safety program.

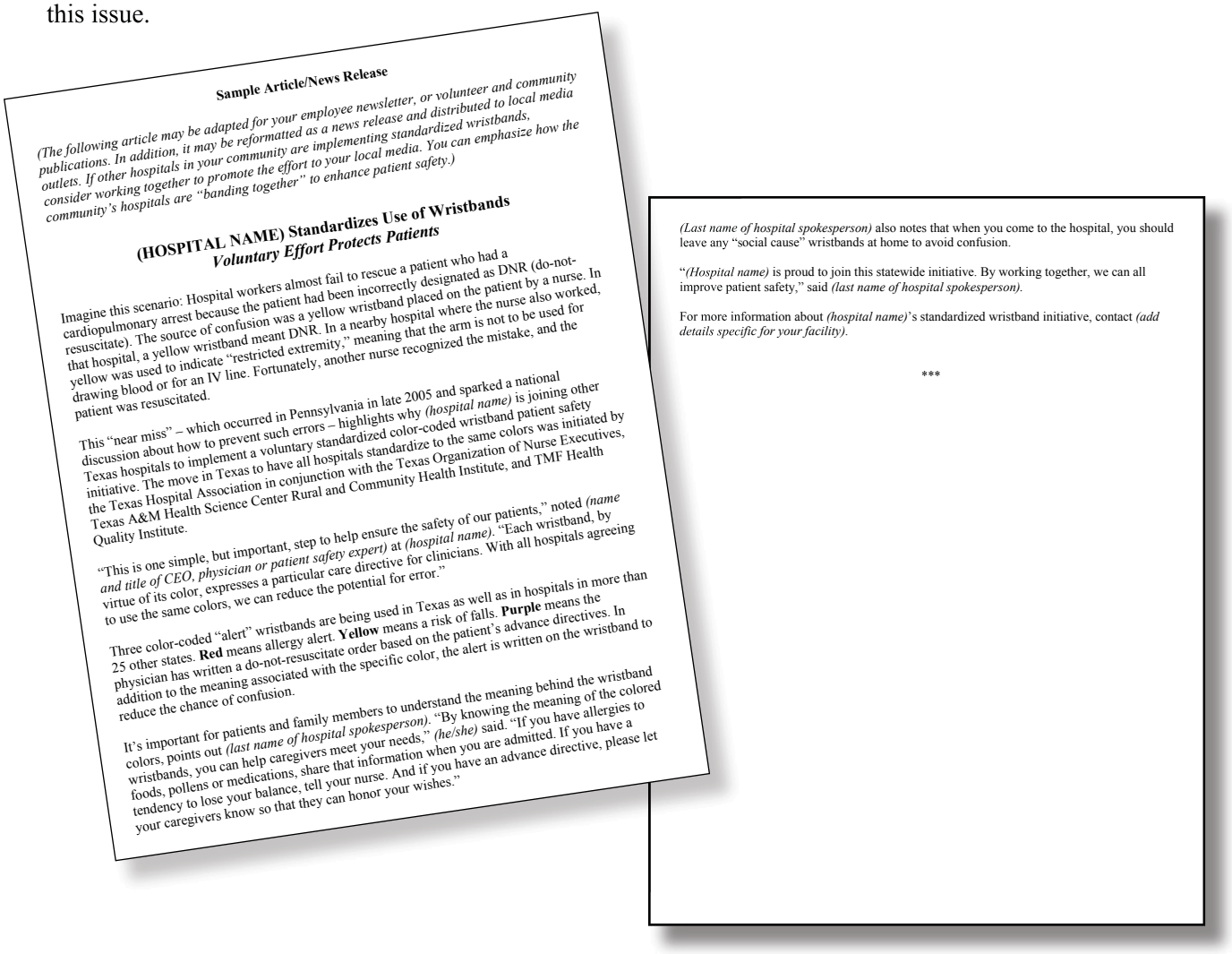
Modelo del texto del manual para el paciente:

ABC Hospital es un participante voluntario de una iniciativa multiestatal para la seguridad del paciente que utiliza pulseras codificadas por colores estandarizados. Los hospitales de Texas y de más de 25 estados han adoptado tres colores estándares para informar al personal acerca de afecciones específicas. Rojo significa alergia, amarillo indica riesgo a sufrir caídas y púrpura refleja la existencia de una orden de no reanimar al paciente. Si un enfermero determina que usted necesita una o más de estas pulseras, ya sea en el momento de la admisión o durante su estadía, recibirá información acerca del tipo de alerta y se le solicitará que use la pulsera. Para evitar confusiones, el hospital exige a los pacientes que se saquen las pulseras que usen por "causas sociales". Para obtener más información, comuníquese con su enfermero. Nuestro objetivo es hacer que la atención sea lo más segura posible, y estas señales visibles ayudan a informar a los integrantes del personal acerca de las afecciones específicas. Gracias por su cooperación en este importante programa de seguridad del paciente.

Teaching Tools

9. Sample News Release (document provided)

Hospitals may want to inform their communities about their adoption of this new patient safety initiative. A story could be placed in the hospital's external newsletter or magazine. Additionally, the hospital could submit a news release to local media outlets. A sample article/news release is provided. Be sure to personalize the copy for your facility. The director of nursing or quality improvement could serve as the spokesperson on this issue.



Sample Article/News Release

(The following article may be adapted for your employee newsletter, or volunteer and community publications. In addition, it may be reformatted as a news release and distributed to local media outlets. If other hospitals in your community are implementing standardized wristbands, consider working together to promote the effort to your local media. You can emphasize how the community's hospitals are "banding together" to enhance patient safety.)

(HOSPITAL NAME) Standardizes Use of Wristbands
Voluntary Effort Protects Patients

Imagine this scenario: Hospital workers almost fail 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 yellow wristband placed on the patient by a nurse. In that hospital, a yellow wristband meant DNR. In a nearby hospital where the nurse also worked, yellow was used to indicate "restricted extremity," meaning that the arm is not to be used for drawing blood or for an IV line. Fortunately, another nurse recognized the mistake, and the patient was resuscitated.

This "near miss" – which occurred in Pennsylvania in late 2005 and sparked a national discussion about how to prevent such errors – highlights why *(hospital name)* is joining other Texas hospitals to implement a voluntary standardized color-coded wristband patient safety initiative. The move in Texas to have all hospitals standardize to the same colors was initiated by the Texas Hospital Association in conjunction with the Texas Organization of Nurse Executives, Texas A&M Health Science Center Rural and Community Health Institute, and TMF Health Quality Institute.

"This is one simple, but important, step to help ensure the safety of our patients," noted *(name and title of CEO, physician or patient safety expert)* at *(hospital name)*. "Each wristband, by virtue of its color, expresses a particular care directive for clinicians. With all hospitals agreeing to use the same colors, we can reduce the potential for error."

Three color-coded "alert" wristbands are being used in Texas as well as in hospitals in more than 25 other states. **Red** means allergy alert. **Yellow** means a risk of falls. **Purple** means the physician has written a do-not-resuscitate order based on the patient's advance directives. In addition to the meaning associated with the specific color, the alert is written on the wristband to reduce the chance of confusion.

It's important for patients and family members to understand the meaning behind the wristband colors, points out *(last name of hospital spokesperson)*. "By knowing the meaning of the colored wristbands, you can help caregivers meet your needs," *(he/she)* said. "If you have allergies to foods, pollens or medications, share that information when you are admitted. If you have a tendency to lose your balance, tell your nurse. And if you have an advance directive, please let your caregivers know so that they can honor your wishes."

(Last name of hospital spokesperson) also notes that when you come to the hospital, you should leave any "social cause" wristbands at home to avoid confusion.

"*(Hospital name)* is proud to join this statewide initiative. By working together, we can all improve patient safety," said *(last name of hospital spokesperson).*

For more information about *(hospital name)*'s standardized wristband initiative, contact *(add details specific for your facility).*

***

Sample Article/News Release

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For more information about *(hospital name)*'s standardized wristband initiative, contact *(add details specific for your facility)*.

***

Policy and Procedure

Sample Policy and Procedure

Sample Patient Refusal Form

Policy and Procedure

A model Policy and Procedure is provided in a Word format so that hospitals may modify as necessary.

In addition, a sample form is provided for situations in which a patient refuses to wear a recommended wristband alert. Hospitals should document a patient's refusal to comply with wearing a wristband alert or removing a "social cause" wristband.

Policy and Procedure Template

Policy name: Color-coded Wristbands

1. Purpose

To have a process that identifies and communicates patient-specific risk factors or special needs by using standardized color-coded wristbands based upon the patient's assessment, wishes and medical status. The wristband colors adopted are being used by hospitals across the nation as a strategy to reduce confusion for staff members who may relocate from another state or work in multiple hospitals.

2. Objectives -- Color-coded Wristbands

Objectives are:

A. To reduce the risk for potential 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," and "DNR."
2. Colored wristbands may be applied or removed only by a nurse or licensed staff person conducting an assessment.
3. 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 as the colored wristband.
4. "Social cause" wristbands, such as "LIVE**STRONG**" and other initiatives, 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 other personal items. This is to avoid confusion with the color-coded wristbands and to enhance patient safety practices. Wristbands designating patients being evacuated or requiring special care during an emergency response should not be removed.
5. To assist the patient and family members in being partners in the care provided and safety measures used, patient and family education should be conducted regarding:
    a) The type of alert each wristband symbolizes and what interventions – if any – are being made to avoid the potential risk, and
    b) The risks associated with wearing social cause wristbands and why patients are asked to remove them.

3. Definitions

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

Band Color	Communication
Red	Allergy
Yellow	Fall Risk
Purple	DNR

4. Identification 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 the 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 Wristbands

During the initial patient assessment, data are 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, and may uncover additional pertinent medical information, trigger key decision points or reveal additional risk factors about the patient. Risk factors associated with falls, allergies and DNR status are identified or modified during the initial and reassessment procedures. Because this is an interdisciplinary process, it is important to identify who has responsibility for applying and removing color-coded wristbands, 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 one of the three risk factors on initial assessment will have a color-coded wristband placed on the same extremity as the admission ID band by the admitting nurse.

B. The application of the color-coded wristband is documented in the chart by the nurse per hospital policy.

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

D. Upon application of the color-coded wristband, the nurse will instruct the patient and his/her 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 band(s). Upon completion of the treatment or procedure, the risk(s) will be reconfirmed and the appropriate color-coded wristband(s) will be placed on the patient's extremity 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 a social cause wristband is present, the nurse will explain the associated risks and ask the patient to remove it. If the patient agrees, the band will be removed and given to a family member to take home, or stored with the patient's other personal belongings. If the patient refuses, the nurse will request that the patient sign a refusal form acknowledging the risks associated with the social cause wristband (see attached document). In the event that the patient is unable to provide permission, and family member(s) or a significant other is not present, the licensed staff member may remove the social cause band(s) to reduce the potential for 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 its significance. It is also important that the patient and family member(s) be acknowledged as valuable members 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. During assessment procedures, the nurse should take the opportunity to educate and re-educate the patient and family members about:

a) The type of alert each wristband symbolizes and what interventions – if any – are being made to avoid the potential risk;
b) The risks associated with wearing social cause wristbands and why they should be removed;
c) The need to notify the nurse whenever a wristband has been removed and not reapplied, or when a new wristband is applied and no explanation is provided.

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

8. Hand-Offs in Care

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

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

9. 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 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 advance directives must occur.

10. Staff Education

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

(*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 your educational initiatives.)

11. Patient Refusal

If the patient receives an orientation as to why wearing a color-coded wristband is appropriate, and refuses to comply, an explanation of the risks will be provided to the patient/family. The nurse will reinforce to the patient that this process provides an opportunity to participate in efforts to prevent errors in care. The nurse will document in the medical record the patient's refusal to wear the color-coded wristband, as well as any explanation provided by the patient or family member. The patient will be asked to complete and sign a release which acknowledges the refusal to wear the recommended color-coded wristband.

{Facility Name}
{Form Number}

Patient Refusal to Cooperate with Color-coded Wristband Standardization Project

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 LIVE**STRONG** and others).

The risks of refusing to remove the "social cause" colored wristband(s) have been explained to me by a member of the health care team. I understand that refusing to remove the "social cause" wristband could cause confusion in my care, and despite this information, I do not give permission for the removal of the "social cause" colored wristband.

Reason provided (if any): _____

_____

_____ _____

Date/Time **Signature/Relationship**

_____ _____

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

Texas Hospital Association wishes to acknowledge the Pennsylvania Color of Safety Task Force, which developed the initial form that is the basis for this document.

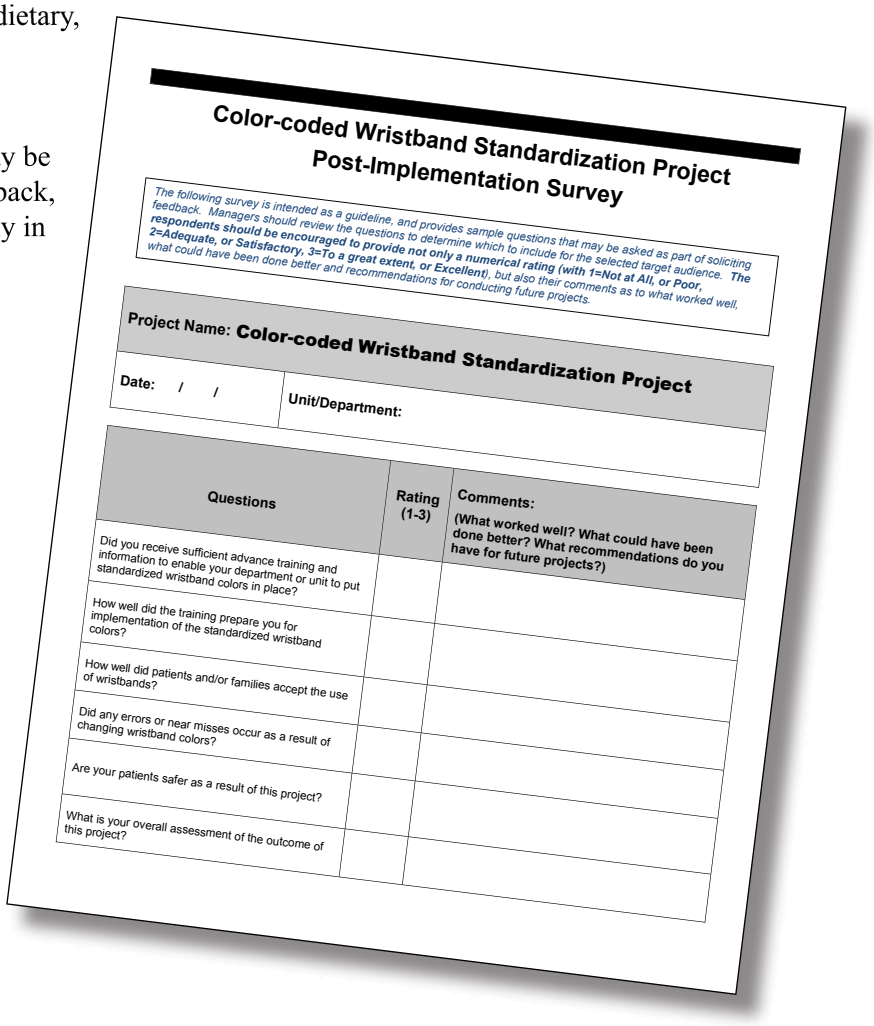
Post-Implementation Survey

Post-Implementation Survey

Post Implementation Survey

Approximately three months after your hospital has implemented the use of standardized color-coded wristbands, a survey to assess the program would be appropriate. A sample questionnaire is provided. The questionnaire can be distributed by units; be sure to cover all shifts. In addition to surveying nursing staff, you may wish to assess general awareness of the program among other staff members, such as admissions, dietary, housekeeping, etc.

Depending on the results of your assessment, additional education may be needed. If you receive positive feedback, be sure to share the success internally in employee communication.



Color-coded Wristband Standardization Project
Post-Implementation Survey

*The following survey is intended as a guideline, and provides sample questions that may be asked as part of soliciting feedback. Managers should review the questions to determine which to include for the selected target audience. **The respondents should be encouraged to provide not only a numerical rating (with 1=Not at All, or Poor, 2=Adequate, or Satisfactory, 3=To a great extent, or Excellent)**, but also their comments as to what worked well, what could have been done better and recommendations for conducting future projects.*

Project Name: Color-coded Wristband Standardization Project

Date: / /

Unit/Department:

Questions	Rating (1-3)	Comments: (What worked well? What could have been done better? What recommendations do you have for future projects?)
Did you receive sufficient advance training and information to enable your department or unit to put standardized wristband colors in place?		
How well did the training prepare you for implementation of the standardized wristband colors?		
How well did patients and/or families accept the use of wristbands?		
Did any errors or near misses occur as a result of changing wristband colors?		
Are your patients safer as a result of this project?		
What is your overall assessment of the outcome of this project?		

Color-coded Wristband Standardization Project
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Acknowledgements

Acknowledgements

With the leadership of the Texas Hospital Association, Texas Organization of Nurse Executives, Texas A & M Health Science Center Rural and Community Health Institute, and TMF Health Quality Institute, Texas hospitals are undertaking a voluntary effort to improve patient safety. These organizations are pleased to share the contents of this work product with any organization.

You may access this information online at www.texashospitalsonline.org/wristband.
To obtain information about this project, please contact:

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WRISTBAND WORKGROUP

A group of dedicated health care professionals in Texas brought this important patient safety initiative to this state. This was a very ambitious task and without their personal involvement and passion for patient safety, this initiative would have not been possible. The Texas Hospital Association thanks and acknowledges those who participated in and contributed to this project:

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SUPPORTING ORGANIZATIONS

The Texas organizations listed below learned about the lack of consistency in wristbands being used in Texas hospitals. They shared the workgroup's patient safety concerns, and they quickly became partners in this endeavor. The Wristband Workgroup acknowledges and appreciates the invaluable support provided by:

BlueCross and BlueShield of Texas

Dallas-Fort Worth Hospital Council Education and Research Foundation

Greater San Antonio Hospital Council

Texas Medical Association

Texas Nurses Association

Texas Organization of Rural & Community Hospitals

Texas Patient Safety Alliance

Texas Pharmacy Congress

CONTRIBUTORS

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Arizona Hospital and Healthcare Association for allowing use and modification of its intellectual property on which this toolkit is based.

Missouri Center for Patient Safety for use of its tag line "*Banding together for patient safety.*"

Minnesota Hospital Association for use of its "human factors" information.

Pennsylvania Color of Safety Task Force for development of the initial policy that is the basis for the toolkit's Policy and Procedure Template.

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