“Patient safety is a top priority”

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Executive Summary

Patient safety is a top priority in Minnesota. We accomplish this in several ways, one which will now include Minnesota hospitals using the same five colors for “alert” wristbands. The goal is that all Minnesota hospitals that use wristbands to communicate an alert will adopt the same colors.

The issue of wristband colors was first raised by the Pennsylvania Patient Safety Authority when there was an event in which a clinician nearly failed to rescue a patient who had a cardiopulmonary arrest because the patient had been incorrectly designated as “DNR” (do not resuscitate). The source of the confusion was that a nurse had incorrectly placed a yellow wristband on the patient. In this hospital, the color yellow signified that the patient should not be resuscitated. In a nearby hospital, in which this nurse also worked, yellow signified “restricted extremity,” meaning that this arm is not to be used for drawing blood or obtaining IV access. Fortunately, in this case, another clinician identified the mistake, and the patient was resuscitated. However, this “near miss” highlights a potential source of error and an opportunity to improve patient safety by re-evaluating the use of color-coded wristbands. Surveys have found up to 10 different colors for DNR and seven various colored bands designating 29 different conditions.

MHA Patient Safety Committee
To proactively address this issue, the MHA Patient Safety Committee commissioned a task force in April of 2007 to evaluate whether or not there should be a statewide standard for wristband colors in Minnesota. At that time there were 11 states that had adopted various standards for wristband colors. The task force learned that though there is limited, or lack thereof, research indicating how standardizing color coded wristbands impacts patient safety, experience from other states indicate that there have not been safety issues during transition to the new standard. In fact, caregivers welcomed the standardization due to potential confusion caused by the numerous variations in the use of color-coded “alert” wristbands.

The MHA board recommends all hospitals work toward reducing reliance on the use of color-coded wristbands (see p. 4 for recommended strategies). In the interim the following color coded wrist bands should be used:

<table>
<thead>
<tr>
<th>Color</th>
<th>Alert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Allergy</td>
</tr>
<tr>
<td>Yellow</td>
<td>Fall Risk</td>
</tr>
<tr>
<td>Purple</td>
<td>DNR</td>
</tr>
<tr>
<td>Pink</td>
<td>Restricted Extremity</td>
</tr>
<tr>
<td>Green</td>
<td>Latex Allergy</td>
</tr>
</tbody>
</table>

Motion Approved by MHA Board
August 10, 2007

Recognizing that current variations in the use of color-coded “alert” wristbands may cause confusion among caregivers, staff, and patients and can lead to patient harm, the Minnesota Hospital Association’s Patient Safety Committee proposes that the MHA board adopt the following resolution:

The Minnesota Hospital Association recommends that all hospitals work toward reducing reliance on and eventually eliminating the use of color wristbands by collectively developing more effective ways to communicate emergency information and patient risks. In the interim, if an organization uses colored wristbands to communicate patient information or risks, the following colors should be used to indicate the respective alert:
Strategies to Reduce Reliance on Wristbands

The ultimate goal of the MHA board motion is to eventually reduce the reliance on wristbands. This goal can be successfully achieved while maintaining patient safety by using technology such as using the patient identification wristband with bar coding.

Understanding that technology, such as bar coding and CPOE, is not a solution for all hospitals, additional strategies are listed below.

Suggested alternative methods for communicating alerts:

- **Signage** — If signage is used, the color schema should be consistent with recommended colors: purple for DNR, red for allergy, yellow for fall risk, pink for restricted extremity and green for latex allergy.

- **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” communications is one of 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 alerts.

- **Situation-Background-Assessment-Recommendation (SBAR)** is one technique to address hand-off communication. 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 understand each other better. Michael Leonard, M.D., physician coordinator of Clinical Informatics, along with colleagues Doug Bonacum and Suzanne Graham at Kaiser Permanente of Colorado in Evergreen, Colorado, developed the (SBAR) technique.


- **Stickers** — Placing a sticker on the patient’s chart is an alternative method to communicate alerts. If stickers are used, the color schema should be consistent with recommended colors: purple for DNR, red for allergy, yellow for fall risk, pink for restricted extremity and green for latex allergy.

- **Technology** — Bar coding: The FDA issued a final rule in 2004 that requires a bar code including the National Drug Code (NDC) on most prescription drugs and on certain over-the-counter drugs. Bar codes on drugs would help prevent medication errors when used with a bar code scanning system and computerized database. 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](http://www.fda.gov/oc/initiatives/barcode-sadr/fs-barcode.html).

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

- **List allergies on medication sheet**
Human Factors Considerations

Human Factors:

• The study of human capabilities and limitations
  – How we think
  – How we act / What we do
  – What we use to do it

• And the application of those principles to the design of tools, systems, tasks, jobs and environments

• For comfortable, effective, and safe human use

Within healthcare, the science of human factors addresses human performance within medical systems, particularly as it relates to processes of care, error management, and patient safety. Error management indicates not only decreasing errors themselves, but also decreasing the opportunity for error-causing situations to arise, by designing safe systems that take a human's capabilities and limitations into account throughout the design process. This is of primary importance when addressing the design of wristbands, a tool used daily in healthcare by every provider.

To fully integrate human factors into wristband design, there are a few key points to emphasize:

• Human error most frequently arises from stressful, busy, uncommon situations. Because of the dynamic nature of healthcare, it is important to create our systems to help staff do their work. By standardizing wristbands across the state, staff no longer have to remember symbols or colors specific to hospitals, they are able to learn a single set of rules for every hospital.

• The text information contained on the wristband should not wrap around the entire wrist. This decreases the chance that information will be missed because it is on the other side of the band and was not seen.

• The MINIMAL amount of information that is required should be displayed on the wristband. Key data should be placed where it is seen first.

• Wristbands should be designed so that they highlight SPECIFIC, PERTINENT information. Too much information can be difficult to distinguish and can get misread or misinterpreted, especially when in a hurry. Visual cues, such as highlighting, can be used to make the information ‘pop out.’ However, the cue should be used consistently, (i.e., if one bracelet is going to have the patient's allergies written out on the band,
Human Factors Considerations continued

all wristbands should have allergy information written out on the band). Also, the style and placement of information should remain consistent for every band. Again, only the absolute minimal amount of information should be placed on the band. Limit abbreviations.

▶ If using icons: Icons can facilitate visual search for information: HOWEVER, the icon must make sense to the user. In other words, if choosing to use an icon, use something the majority of users recognize as representative of the information trying to be conveyed.

▶ If using numbers: Numbers can be read more quickly if they are in a column than in a row. However, remember that information should not wrap around the entire wrist.

▶ If using any extended text: Font should never be smaller than 8 pt. Spacing between lines is very important. This is called “white space.” Lines should always be at least single spaced. For short, factual information, a table with lines is helpful to keep information separate.

<table>
<thead>
<tr>
<th>Smith, Joseph B.</th>
<th>Birth date: September 30, 1947</th>
</tr>
</thead>
<tbody>
<tr>
<td>DNR</td>
<td>Male</td>
</tr>
</tbody>
</table>

In closing, taking human factors – human capabilities and limitations – into account will allow for a safer and more intuitive system. As a rule of thumb, simpler is ALWAYS better. The recommendations here are based on a broad spectrum of possible bracelet designs, highly dependent on the amount of text and the length of text. The recommendations here are based on scientific research into human abilities to see, read, and perceive and interpret information. For a complete list of references, please email Sarah Henrickson at henrickson.sarah@mayo.edu.

Human Factors Resources

Helping clinicians to find data and avoid delays. The Lancet, Volume 352, Issue 9138, Pages 1462-1466, E. Nygren, J. Wyatt, P. Wright

How to limit clinical errors in interpretation of data. The Lancet, Volume 352, Issue 9139, Pages 1539-1543, P. Wright, C. Jansen, J. Wyatt

“Patient safety is a top priority”
Recommendations for Adoption — Purple

**Do Not Resuscitate**

Recommendation:

It is recommended that hospitals adopt the color of PURPLE for the Do Not Resuscitate designation with the letters embossed/printed on the wristband, “DNR.”

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

**FAQs**

**Q. Why should we consider adopting this?**

**A.** Wristbands are used in many Minnesota hospitals to communicate an alert. Until more effective ways of communicating patient DNR designation are developed, a wristband can serve as a quick warning to communicate this alert.

**Q. Why not use blue?**

**A.** At first, blue was considered a great color choice; however, many hospitals utilize “Code Blue” to summon the resuscitation team. By also having the DNR wristband as “no code” there was the potential to create confusion. “Does blue mean we code or do not code?” To avoid creating any second guesses in this critical moment, we opted to not use blue.

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Recommendations for Adoption — Red

Allergy Alert

Recommendation:

It is recommended that hospitals adopt the color of RED for the Allergy Alert designation. Hospitals should develop a consistent process for indicating specific allergy (noted in medical record, written on band etc.).

FAQs

Q. Why did you select red?

A. Red was selected to be consistent with the 3 state models evaluated, which use the color red to indicate an allergy. It just made sense to continue with an established color that has been implemented in 11 other states.

Q. Are there any other reasons for using red?

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

“Patient safety is a top priority”
Recommendations for Adoption — Yellow

**Fall Risk**

Recommendation:

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

**FAQs**

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

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

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

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

According to the CDC:

1. More than a third of adults aged 65 years or older fall each year.
2. Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes.
3. Of those who fall, 20% to 30% suffer moderate to severe injuries that reduce mobility and independence, and increase the risk of premature death.
4. The total cost of all fall injuries for people age 65 or older in 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 steadily increased, from 230,000 admissions in 1988 to 338,000 admissions in 1999.
6. The number of hip fractures is expected to exceed 500,000 by the year 2040. As the aging population enters the acute care environment, one must consider the risk that is present and do all possible to communicate that to hospital staff. For more information about falls and related statistics, go to: [http://www.cdc.gov/ncipc/factsheets/fallcost.htm](http://www.cdc.gov/ncipc/factsheets/fallcost.htm).

“Patient safety is a top priority”
Recommendations for Adoption — Pink

**Recommendation:**

It is recommended that hospitals adopt the color of PINK for the Restricted Extremity Alert designation with the words embossed / written on the wristband, “Restricted Extremity.”

**FAQs**

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

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

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

**A.** Pink is consistent with other state models such as Pennsylvania and Colorado.

“Patient safety is a top priority”
**Recommendations for Adoption — Green**

**Latex Allergy**

Recommendation:

It is recommended that hospitals adopt the color of GREEN for the Latex Allergy Alert designation with the words embossed / written on the wristband, “Latex Allergy.”

**FAQs**

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

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

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

**A.** Green is consistent with other state models such as Pennsylvania.

“Patient safety is a top priority”
**Color-coded Wristband Standardization in Minnesota**

**Risk Reduction Strategies**

**Color-coded “Alert” Wristbands / Risk Reduction Strategies**

**Quick Reference Card**

1. Use wristbands with the alert message pre-printed (such as “DNR”).
2. Remove any “social cause” colored wristbands (such as “Live Strong”).
3. Remove wristbands that have been applied from another facility.

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

The following information takes each risk reduction strategy and provides further detail and/or explanation of that strategy.

1. **Use wristbands that are pre-printed with text that tells what the wristband means.**
   - a. This can reinforce the color coding system for new clinicians, help caregivers interpret the meaning of the wristband in dim light, and also help those who may be color blind.
   - b. Eliminates the chance of confusing colors with alert messages.

2. **Remove any “social cause” (such as Live Strong, Cancer, etc.) colored wristbands.**
   - a. Be sure this is addressed in your hospital policy.
   - b. If that can’t be done, you can cover the wristband with a bandage or medical tape, but removal altogether is best.

3. **Remove wristbands that have been applied from another facility.**
   - a. This should be done during the entrance to facility process and/or admission.
   - b. Be sure this is addressed in your hospital policy.

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

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

6. **Coordinate chart/white board/care plan/door signage information/stickers with same color coding.**
   - For allergies, fall prevention, DNR, restricted extremity and latex allergy status.

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

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Additional Points to Make:

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

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

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

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

Risks are about events that, when triggered, may cause potential harm, significant injury or in the worse case scenario, death of a patient. The commitment to practice safely begins at the bedside and is underscored through leadership support to be proactive in the effort to ensure safe practice.

The initial step begins with risk identification. Trends in adverse events or “the risk thereof” are key to organizational claim management. Failure to rescue, medication errors, and falls consistently challenge organizations to improve patient safety and reduce losses. Medication errors and falls are among the highest reported incidents and are often underestimated “based on their everyday occurrence.” Human factors are often the root cause of such preventable events and are often related to a complicated communication process, an ever-changing environment, and inconsistent caregivers.

Communication is a leading contributing factor for sentinel events that occur in the healthcare setting. One method to assist with effective communication is using color coding for “alert” wristbands. This provides a simplified tool that, when standardized, provides a continuous communication link within an organization as well as between other healthcare facilities.

“Patient safety is a top priority”
“Patient safety is a top priority”
Policy and Procedure Template

Policy name: Color-coded Wristbands

1. **Purpose**

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

2. **Objective - Color-coded Wristbands**

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

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

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

<table>
<thead>
<tr>
<th>Band Color</th>
<th>Communicates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Allergy</td>
</tr>
<tr>
<td>Yellow</td>
<td>Fall Risk</td>
</tr>
<tr>
<td>Purple</td>
<td>DNR</td>
</tr>
<tr>
<td>Pink</td>
<td>Restricted Extremity</td>
</tr>
<tr>
<td>Green</td>
<td>Latex Allergy</td>
</tr>
</tbody>
</table>

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

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

5. **Color-coded Hospital Bands**

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

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

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

C. If labels, stickers or other visual cues are used to document in the record, the stickers should correspond to band color and text.
D. Upon application of the colored band, the nurse will instruct the patient and their family member(s) (if present) that the wristband is not to be removed.

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

6. **Social Cause Wristbands**

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

7. **Patient / Family Involvement and Education**

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

a) The meanings of the hospital wristbands and the alert associated with each wristband;

b) The risks associated with wearing social cause wristbands and why they are asked to remove them;

c) The nurse whenever a wristband has been removed and not reapplied; or

d) Notify the nurse when a new band is applied and they have not been given explanation as to the reason.

Patients and families have available to them a patient/family education brochure (see pages 32-33) that explains this information as well.
8. **Hand-Off in Care**

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

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

9. **DNR (Do Not Resuscitate)**

DNR (Do Not Resuscitate) status and all other risk assessments are determined by individual hospital policy, procedure and/or physician order written within and acknowledged within that care setting only. The color-coded wristband serves as an alert and does not take the place of an order. Do Not Resuscitate orders must be written and verification of Advanced Directives must occur.

10. **Staff Education**

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

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

11. **Patient Refusal**

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

Patient Identifier Information

Name: ____________________________________

PID: _____________________________________

DOB: ____________________________________

Admitting Physician: _______________________

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

☐ Wear color coded alert wristbands.

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

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

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

Reason provided (if any): _____________________________________________________________________

_____________________________________________________________________________________

Date / Time  Signature / Relationship

__________________________________________________________

Date / Time  Witness Signature / Job Title

__________________________________________________________
Staff and Patient Education Materials

- DNR
- ALLERGY
- FALL RISK
- RESTRICTED EXTREMITY
- LATEX ALLERGY

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Staff Education Training Tips

Key Preparation Before You Start

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

Thoughts to consider:

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

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

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

4. Don’t make assumptions about the medical staff getting this information. Attendings, intensivists, residents and interns need to know what these colors mean. Pull them into the process. This promotes safe healthcare for all providing it and receiving it.

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

“Patient safety is a top priority”
Getting Started

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

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

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

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

   The story goes like this:

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

   We want to thank and acknowledge this hospital for their transparency and disclosure of this event. It could have happened anywhere, and it has served as a “wake-up call” to many of us.
Introduce the Colors – There are five different color-coded “alert” wristbands that we are going to discuss that are a part of the statewide standardization.

- **RED** means ALLERGY ALERT
- **YELLOW** means FALL RISK
- **PURPLE** means “DNR” or Do Not Resuscitate
- **PINK** means RESTRICTED EXTREMITY
- **GREEN** means LATEX ALLERGY

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

1. Use wristbands with the alert message pre-printed (such as “DNR”).
2. Remove any “social cause” colored wristbands (such as “Live Strong”).
3. Remove wristbands that have been applied from another facility.
4. Initiate banding upon admission, changes in condition, or when information is received during hospital stay.
5. Educate patients and family members regarding the wristbands.
6. Coordinate chart/white board/care plan/door signage information/stickers with same color coding.
7. Educate staff to verify patient color-coded “alert” arm bands upon assessment, hand-off of care and facility transfer communication.

“Patient safety is a top priority”
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 wristband means.
   a. This can reinforce the color coding system for new clinicians, help caregivers interpret the meaning of the wristband in dim light, and also help those who may be color blind.
   b. Eliminates the chance of confusing colors with alert messages.

2. Remove any “social cause” (such as Live Strong, Cancer, etc.) colored wristbands.
   a. Be sure this is addressed in your hospital policy.
   b. If that can’t be done, you can cover the wristband with a bandage or medical tape, but removal altogether is best.

3. Remove wristbands that have been applied from another facility.
   a. This should be done during the entrance to facility process and/or admission.
   b. Be sure this is addressed in your hospital policy.

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

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

6. Coordinate chart/white board/care plan/door signage information/stickers with same color coding.
   For allergies, fall prevention, DNR, restricted extremity, and latex allergy status.

7. Educate staff to verify patient color-coded “alert” wristbands upon assessment, handoffs of care and facility transfer communication.

Additional points to make:

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

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

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

SCRIPT for any staff person talking to a patient or family

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

What do the colors mean?
There are FIVE different color-coded “alert” wristbands that we are going to discuss because they are going to be standardized throughout the state.

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

YELLOW means FALL RISK
We want to prevent falls at all times. Nurses review patients all the time to determine if they need extra attention in order to prevent a fall. Sometimes, a person may become weakened during their illness or because they just had a surgery. When a patient has this color-coded alert wristband, the nurse is saying this person needs to be assisted when walking or they may fall.

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

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

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

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

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

Go to MHA’s web site at www.mnhospitals.org. Click on “Priority Issues,” “Patient Safety,” then “Tools.” The toolkit can be found under the “Minnesota Wristband Color Toolkit” heading.
Join us on the following dates for the training session about Color-coded Alert Wristband Standardization.

Day / Date / Time: ____________________________________________________________
Location: __________________________________________________________________

Day / Date / Time: ____________________________________________________________
Location: __________________________________________________________________

Day / Date / Time: ____________________________________________________________
Location: __________________________________________________________________

Questions? Contact: ___________________________________________ ext: ____________

“Patient safety is our first priority”
Staff Sign-In Sheet

Date: ____________________  Unit/Dept/ Location _____________________________________

Educator: ____________________________________________________________

Topic: **Color-coded Alert Wristbands**

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

Name/Title: ____________________________________________  Shift: __________

Name/Title: ____________________________________________  Shift: __________

Name/Title: ____________________________________________  Shift: __________

Name/Title: ____________________________________________  Shift: __________

Name/Title: ____________________________________________  Shift: __________

Name/Title: ____________________________________________  Shift: __________

Name/Title: ____________________________________________  Shift: __________

Name/Title: ____________________________________________  Shift: __________

Name/Title: ____________________________________________  Shift: __________

Name/Title: ____________________________________________  Shift: __________

Name/Title: ____________________________________________  Shift: __________

Name/Title: ____________________________________________  Shift: __________
Staff Competency Checklist

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

### Methods to Use:

<table>
<thead>
<tr>
<th>Method to Use</th>
<th>A. Demonstration</th>
<th>B. Direct Observation/Checklist</th>
<th>C. Video / PowerPoint Review</th>
<th>D. Skills Lab</th>
<th>E. Self Study/Test</th>
<th>F. Data Management</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor's initials signify competency was met.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Patient Color-coded Alert Wristband Process</th>
<th>Date</th>
<th>Method Used</th>
<th>Supervisors’ Initials</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Color Code – what do the five colors mean?</td>
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<tr>
<td>Who can apply the wristband to the patient?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Job Title</th>
<th>Signature</th>
<th>Initials</th>
<th>Signature</th>
<th>Initials</th>
</tr>
</thead>
</table>

Employee Signature

Initials

Employee Signature

Date

MHA wishes to acknowledge the Pennsylvania Color of Safety Task Force, which developed the initial policy that is the basis for this document.
How this all got started...

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

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

*To view the entire safety alert go to http://www.psa.state.pa.us/psa/lib/psa/advisories/v2_s2_sup__advisory_dec_14_2005.pdf

The Big Picture

Statewide wristband color standardization is being adopted throughout Minnesota, in addition to many southwestern states through the Western Region Alliance for Patient Safety (WRAPS): Arizona, California, Colorado, Nevada, New Mexico and Utah. Other states include Ohio, West Virginia and Pennsylvania. That means whether you are traveling on vacation to these states or relocated to work in another state, most hospitals will be using consistent colors.

Minnesota has adopted five colors:

RED means ALLERGY ALERT

YELLOW means FALL RISK

PURPLE means “DNR”

PINK means “RESTRICTED EXTREMITY”

GREEN means “LATEX ALLERGY”

Color-coded wristbands in Minnesota

Patient safety is a top priority for Minnesota. To proactively address the safety risk due to wristband color variation, the Minnesota Hospital Association (MHA) Patient Safety Committee commissioned a task force to evaluate whether or not there should be a statewide standard for wristband colors in Minnesota. At that time there were 11 states that had adopted various standards for wristband colors. Though there is limited, or lack thereof, research indicating how standardizing color coded wristbands impacts patient safety, experience from other states that have implemented a standard indicated that there have not been safety issues during transition to the new standard.

In addition, caregivers welcomed the standardization due to potential confusion caused by the numerous variations in the use of color-coded “alert” wristbands.

Staff Education

Regarding:

Color-coded “alert” wristbands

Information intended for all staff, clinical and non-clinical.
Various surveys have been conducted indicating that there are over 10 different colors for DNR and that seven various colored bands were used to designate twenty-nine different conditions.

Our risk was apparent.

Solution: Standardize the colors being used for alerts: allergies, fall risk, DNR, restricted extremity, and latex allergy in all Minnesota hospitals.

How to tell the patients what the different colors mean?

How we say something is just as important as what we say. The next column is a script you can use to tell your patients / families about the color-coded alert wristbands and what they mean. If everyone says it the same way, there is a better chance patients and families will understand what we are saying.
Our hospital is proud to be a supporter of this work, making healthcare safer and better for patients and their families.

Minnesota healthcare providers are working together to make patients safe. We accomplish this goal by working together on projects like using the same color-coded wristbands.

Photo compliments of Motion Computing
Statewide Patient Safety Initiatives

Patient safety is a top priority for Minnesota. We accomplish this in several ways, one which includes using the same colors for “alert” wristbands. This initiative is not only throughout our state, but in many other states including Arizona, California, Colorado, Nevada, New Mexico, Ohio, Oregon, Ohio, Pennsylvania, Utah, and West Virginia.

What is a Color-coded “Alert” Wristband?

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

What do the different colors mean?

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

**RED means ALLERGY ALERT**

If you have an allergy to anything – food, medicine, dust, grass, pet hair, ANYTHING – tell us. It may not seem important to you but it could be very important in the care you receive.

**YELLOW means FALL RISK**

We want to prevent falls at all times. Your provider will determine if you need extra attention in order to prevent a fall. Sometimes, a person may become weakened during their illness or because they just had a surgery. When a patient has this color-coded alert wristband, it indicates this person needs to be assisted when walking or they may fall.

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

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

**PINK means “Restricted Extremity”**

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

**GREEN means “Latex Allergy”**

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

Involving Patients and Family Members

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

**Keep us informed.**

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

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

*PowerPoint Presentation*

This presentation was created to provide alternate teaching methods for the trainer. It can be used in large and small groups. The presentation with “Speaker’s Notes” is available on the Toolkit CD.

“Patient safety is a top priority”
**Color Coded Wristband Standardization in Minnesota**

**Executive Summary**

**Surveys have found that:**

- up to 10 different colors are used for DNR
- seven various colored bands are used to designate twenty-nine different conditions
- there are 11 variations of wristband colors just among MHA’s Wristband Task Force.

**Background:**

- In 2005, Pennsylvania had a ‘near miss’ when there was confusion regarding wristband color that resulted in a patient being labeled DNR erroneously
- MHA Patient Safety Committee commissioned a task force to evaluate whether or not Minnesota should have a statewide standard for wristband colors
- As of August 2007, 11 states standardized wristband colors

**What did we do?**

- Reviewed current standardization models in use
- Discussed potential safety issues during transition to new standard and staff impact
  - Limited research on topic - incorporated human factors concepts
  - Other state experience indicated no safety issues during transition
  - Caregivers have welcomed the standardization due to potential confusion caused by the numerous variations in the colors.

**Task force findings discussed at full MHA Patient Safety Committee**

**Consensus to forward motion to MHA board to standardize five condition alerts**

- Do Not Resuscitate ‘DNR’
- Allergy
- Fall Risk
- Restricted Extremity
- Latex Allergy

**Board motion approved August 2007**
Recognizing that current variations in the use of color-coded "alert" wristbands may cause confusion among caregivers, staff, and patients and can lead to patient harm, the Minnesota Hospital Association’s Patient Safety Committee proposes that the MHA board adopt the following resolution:

The Minnesota Hospital Association recommends that all hospitals work toward reducing reliance on and eventually eliminating the use of color wristbands by collectively developing more effective ways to communicate emergency information and patient risks. In the interim, if an organization uses colored wristbands to communicate patient information or risks, the following colors should be used to indicate the respective alert:

- *Red: allergy*
- *Yellow: fall risk*
- *Purple: DNR*
- *Pink: restricted extremity*
- *Green: latex allergy*

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

**Recommendation:**

**Allergy - Red**

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

Red means ‘Stop!’

The American National Standards Institute has designated red to communicate ‘Stop!’ or ‘Danger’.
1. **Why Red?**
   - All 11 states to date have adopted red for allergy.

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

3. **Do we write the allergies on the wristband too?**
   - Hospitals will need to determine a consistent process for communicating the specific allergy. Some hospitals may choose not to write on the band due to:
     - Legibility issues
     - Allergy list may change
     - Patient chart should be the source for the specifics

---

**Do Not Resuscitate**

**Recommendation:**

- **DNR - Purple**

   It is recommended that hospitals adopt the color PURPLE for the Do Not Resuscitate designation.

---

**Fall Risk**

**Recommendation:**

- **Yellow**

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

---

**Restricted Extremity**

**Recommendation:**

- **Pink**

   When a patient has this color-coded wristband, it is alerting the health provider that the patient’s extremity should be handled with extreme care. This alerts providers to check with the nurse prior to any tests or procedures.

---

**Allergies**

Falls account for more than 70 percent of the total injury-related health care costs among people 60 years of age and older.
**Recommendation - Green for Latex Allergy**

1. **Why Green?**
   
   When a patient has this color-coded wristband, it indicates an allergic reaction to latex. This green wristband will alert the doctors, nurses, and other health care professionals about latex allergies.
1. Use wristbands with the alert message pre-printed (such as “DNR”).
2. Remove any “social cause” colored wristbands (such as “Live Strong”).
3. Remove wristbands that have been applied from another facility.

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

**Why have a Script for Staff?**

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

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

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

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

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

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

**GREEN** means Latex Allergy
When a patient has this color-coded wristband, it indicates an allergic reaction to latex. This green wristband will alert the doctors, nurses, and other health care professionals about latex allergies.
Color Coded Wristband Standardization in Minnesota

**Policy and Procedure**

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

www.mnhospitals.org

---

**Color Coded Wristband Standardization in Minnesota**

**Excerpt from Refusal Form**

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

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

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

Reason provided (if any): __________________________________________

Date / Time   Signature / Relationship

Date / Time   Witness Signature / Job Title

---

**Resources**

- To access an online version of this Tool Kit go to the MHA patient safety page at: www.mnhospitals.org, click on “Priority Issues,” “Patient Safety,” then “Tools.” The toolkit can be found under the ‘Minnesota Wristband Color Toolkit’ heading.

- To access the Pennsylvania Patient Safety Advisory report go to: http://www.psa.state.pa.us/psa/lib/psa/advisories/v2_s2_sup_advisory_dec_14_2005.pdf

- Questions? [Add facility-specific contact information here]

www.mnhospitals.org
Work Plan — How to Implement

- **DNR**
- **ALLERGY**
- **FALL RISK**
- **RESTRICTED EXTREMITY**
- **LATEX ALLERGY**

“Patient safety is a top priority”
Suggested Work Plan for Facility Preparation, Staff Education and Patient Education

**Area #1**

**Organizational Approval**
See Task Chart for specific steps

**Review**

√ Adopting this initiative may need approval by appropriate committees, such as:
  ~ Patient Safety Committee
  ~ Medical Staff Committee
  ~ Quality Improvement Council
  ~ Board of Directors

**Action Plan**

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

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

**Area #2**

**Supplies Assessment and Purchase**
See Task Chart for specific steps

**Review**

√ Assessment of current supply
√ Wristband procurement

**Action Plan**

Most organizations have a vendor they are using for wristbands. Most vendors are aware of the initiative and what bands should be ordered. However, if they do not know, inform them of the colors and the alert message needs to be printed directly on the wristband (please see “Vendor Information” section). They do need some lead time for the imprinting (about 2-3 weeks).

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

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

“Patient safety is a top priority”
## Area #3

### Hospital Specific Documentation

**Review**

- ✔ Policy adoption
- ✔ Assessment Revision
- ✔ Forms revised to meet standards
- ✔ Consents

**Action Plan**

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

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

If a patient refuses to wear a wristband, do you have a document indicating this? Perhaps this needs to be discussed at P&P committee. A sample has been provided in this toolkit.

**Coordinate with:** Risk Management Staff and individual Hospital Administrators

## Area #4

### Staff and Patient Orientation, Education and Training

**Review**

- ✔ Schedule/training content
- ✔ Documentation requirement
- ✔ Posters & FAQs

**Action Plan**

Education format and training materials need to be reviewed.

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

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

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

**Coordinate with:** Individual Hospital Education Staff

---

"Patient safety is a top priority"
### Suggested Task Chart for Facility Preparation

#### Task Chart for Facility Preparation

#### Area #1 Organizational Approval & Awareness

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

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

**STEP 2** When: **WEEK ONE**

<table>
<thead>
<tr>
<th>What to Do</th>
<th>Notes / Comments / Follow-ups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find out when the next meetings are and get on agenda to present the initiative for purpose of acquiring approval or conveying information.</td>
<td><strong>Committee</strong></td>
</tr>
<tr>
<td>NOTE: Not all committees will need to approve this initiative however, they will usually benefit from a presentation that provides the information about this initiative so they can support it. This is equally important and should be considered a priority as well.</td>
<td>Patient Safety Comm.</td>
</tr>
<tr>
<td></td>
<td>Medical Staff Comm.</td>
</tr>
<tr>
<td></td>
<td>Nursing Practice Council</td>
</tr>
<tr>
<td></td>
<td>Quality Improvement Council</td>
</tr>
<tr>
<td></td>
<td>Board of Directors</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

**“Patient safety is a top priority”**
# Task Chart for Facility Preparation

## Area #1 Organizational Approval & Awareness

### STEP 3  When: Pending Committee Approvals

<table>
<thead>
<tr>
<th>What to Do</th>
<th>Notes / Comments / Follow-ups</th>
</tr>
</thead>
<tbody>
<tr>
<td>After presentations made and approval obtained to adopt recommendations, contact pertinent department/staff to move forward, convey appropriate information.</td>
<td><strong>Dept.</strong></td>
</tr>
</tbody>
</table>
| **Materials Management** | 1. Approvals obtained.  
2. OK to order wristbands.  
3. When will bands be available?  
   Take that date and add 5-7 more days – that is your “Go Live” date.  
   (The 5-7 more days are added to allow for distribution of wristbands to pertinent areas.) | How long until delivery? |
| **Staff Education** | 1. Wristbands will be arriving in about __________ weeks.  
2. “Go Live” Date is ______ weeks.  
3. OK to start education. | |
| **Risk Management and/or QI Director** | 1. Wristbands will be arriving in about _________ weeks.  
2. “Go Live” date is _________ weeks.  
3. Confirm P&P has been approved and prepare to add to P&P manual. | |
| **Other Departments to consider:**  
Medical Staff, Admitting, ED, Peri-Op, Nursing, Lab, Dietary, Laboratory, Radiology, Pharmacy, etc. | 1. Wristbands will be arriving in about _________ weeks.  
2. “Go Live” Date is _________ weeks.  
3. OK to start education. Coordinate with Education department for either materials / training / or information. | |
## Task Chart for Facility Preparation

### Area #1 Organizational Approval & Awareness

<table>
<thead>
<tr>
<th>STEP 4</th>
<th>If any other steps required, add them here.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What to Do</strong></td>
<td><strong>Notes / Comments / Follow-ups</strong></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 5</th>
<th>If any other steps required, add them here.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What to Do</strong></td>
<td><strong>Notes / Comments / Follow-ups</strong></td>
</tr>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 6</th>
<th>If any other steps required, add them here.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What to Do</strong></td>
<td><strong>Notes / Comments / Follow-ups</strong></td>
</tr>
<tr>
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<td></td>
</tr>
</tbody>
</table>

“Patient safety is a top priority”
**Task Chart for Facility Preparation**

## Area #2 Supplies Assessment and Purchase

### STEP 1

**When:** WEEK ONE  
**enter date this is done:** 

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

### STEP 2

**When:** WEEK ONE  

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

### STEP 3

**When:** WEEK ONE  

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

---

“Patient safety is a top priority”
### Task Chart for Facility Preparation

#### Area #2 Supplies Assessment and Purchase continued

**STEP 4** When: **WEEK TWO**

<table>
<thead>
<tr>
<th>What to Do</th>
<th>Other Notes / Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up with MM in a week and validate that they were able to contact vendor.</td>
<td>Lead time required when ordering wristbands is:</td>
</tr>
<tr>
<td></td>
<td>ALLERGY Wristband: ________ weeks</td>
</tr>
<tr>
<td></td>
<td>FALL Wristband: ________ weeks</td>
</tr>
<tr>
<td></td>
<td>DNR Wristband: ________ weeks</td>
</tr>
<tr>
<td></td>
<td>RESTRICTED EXTREMITY Wristband: ________ weeks</td>
</tr>
<tr>
<td></td>
<td>LATEX ALLERGY Wristband: ________ weeks</td>
</tr>
<tr>
<td>Complete info in right column from MM.</td>
<td><strong>STEP 5</strong></td>
</tr>
<tr>
<td></td>
<td><strong>STEP 6</strong> If any other steps required, add them here.</td>
</tr>
<tr>
<td></td>
<td><strong>STEP 7</strong> If any other steps required, add them here.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What to Do</th>
<th>When to Do It</th>
<th>Other Notes / Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
<td>Give status report within a month of initial contact so MM knows this is still being worked on.</td>
</tr>
</tbody>
</table>

**“Patient safety is a top priority”**
## Task Chart for Facility Preparation

### Area #3 Hospital Specific Documentation

<table>
<thead>
<tr>
<th><strong>STEP 1</strong></th>
<th><strong>When:</strong> WEEK TWO or THREE</th>
<th><strong>enter date this is done:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What to Do</strong></td>
<td><strong>Other Notes and Cues</strong></td>
<td></td>
</tr>
<tr>
<td>Contact chief nursing officer and clinical directors to review if documentation records contain specific information about wristbands, such as daily nursing charting. <strong>Remember:</strong> This is not a recommendation to add “wristbands” to your documentation process or color specific information, but to review your current documents / process.</td>
<td>Coordinate with chief nursing officer and clinical directors. It may be helpful or more efficient for you to pull the daily documentation information for the various areas and review the current requirement. Consider these documents: ED Triage record or Treatment / ED Nurses Notes Admitting Assessment ICU Nurses Notes Peri-Op Assessments / Notes Daily Nursing Documentation Other:</td>
<td></td>
</tr>
</tbody>
</table>

| **STEP 2** | **When:** WEEK TWO or THREE |  | |
|------------|-------------------------------|-----------------| |
| **What to Do** | **Other Notes and Cues** | | |
| If your current documentation addresses wristband information, review documents to assure any reference to colors are updated to reflect these changes. | Again, this is not a recommendation that the documentation reflect color information about wristbands. However, if your documentation is color specific, this is a cue to validate that the information be updated to reflect the new colors – if that is your current process. | |

| **STEP 3** | **When:** WEEK THREE or FOUR |  | |
|------------|-------------------------------|-----------------| |
| **What to Do** | **Other Notes and Cues** | | |
| If changes are required to the documentation forms, contact Forms Committee and pertinent clinical directors and initiate process for changes. | Some organizations require any changes to forms be reviewed through a “Forms Committee” or similar entity. Other organizations do not require this process if the information being changed is minimal and does not change “content.” This step is to determine your organization’s process. | |

| **STEP 4** | **When:** WEEK THREE or FOUR |  | |
|------------|-------------------------------|-----------------| |
| **What to Do** | **Other Notes and Cues** | | |
| Once process is known, and if a form(s) update is required, factor the print time and new form availability into the time line so the education and implementation processes are in sync with the arrival of new documents. | | |
**Task Chart for Facility Preparation**

**Area #3 Hospital Specific Documentation**

**STEP 5** When: **WEEK FOUR**

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

**STEP 6** When: **WEEK FOUR**

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

**STEP 7**

<table>
<thead>
<tr>
<th>What to Do</th>
<th>Other Notes and Cues</th>
</tr>
</thead>
</table>
| Get this item on P&P committee agenda and have approval for the changes. Coordinate this with the departments that have “unique” P&Ps so all are changed at the same time. | P&P Committee Contact / ext. ____________________________________________________
Date / Month on P&P Committee                                                                 |
Communicate the P&P Committee date to other pertinent directors so the proposed changes are reviewed and agreed upon before P&P Committee date. |

“Patient safety is a top priority”
### Task Chart for Facility Preparation

#### Area #3 Hospital Specific Documentation  
**continued**

<table>
<thead>
<tr>
<th>STEP</th>
<th>If any other steps required, add them here.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td><strong>What to Do</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Other Notes and Cues</strong></td>
</tr>
<tr>
<td>9</td>
<td><strong>What to Do</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Other Notes and Cues</strong></td>
</tr>
<tr>
<td>10</td>
<td><strong>What to Do</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Other Notes and Cues</strong></td>
</tr>
</tbody>
</table>

“Patient safety is a top priority”
# Task Chart for Staff / Patient Education

## Area #4 Staff and Patient Education

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

<table>
<thead>
<tr>
<th>What to Do</th>
<th>Other Notes and Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarize yourself with training content and the tools (FAQs, brochures, Posters &amp; more).</td>
<td>Review the contents of the Education session 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 the directors all of the information about the tools and training section in this manual, they can make a better and informed decision.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>What to Do</th>
<th>Other Notes and Cues</th>
</tr>
</thead>
</table>
| Determine the education format by discussing with the Education Department and clinical directors. By education format we refer to the way the education is going to be managed - at the unit specific level or in a general session where multiple departments are present. Also, is the education going to be facilitated through the department specific directors or Education Department? | **Education Dept. preferences are:**  
____ Unit Specific  
____ General session  
____ Other (explain ____________________________)  

**Facilitator Preferences:**  
____ Unit Based  
____ Educ Dept.  

**Critical Care Dir. preferences are:**  
____ Unit Specific  
____ General session  
____ Other (explain ____________________________)  

**Facilitator Preferences:**  
____ Unit Based  
____ Educ Dept.  

**Med / Surg Dir. preferences are:**  
____ Unit Specific  
____ General session  
____ Other (explain ____________________________)  

**Facilitator Preferences:**  
____ Unit Based  
____ Educ Dept.  

**Pharmacy Dir. preferences are:**  
____ Unit Specific  
____ General session  
____ Other (explain ____________________________)  

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

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

“Patient safety is a top priority”
## Task Chart for Staff / Patient Education

**Area #4 Staff and Patient Education continued**

### STEP 4 When: THREE to FOUR weeks

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

### STEP 5 When: TWO weeks before Train the Trainer Session

<table>
<thead>
<tr>
<th>What to Do</th>
<th>Other Notes and Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make one copy of the Education section of this toolkit for each trainer so they each have their own set of materials. Don’t forget about the PowerPoint presentation too. Some organizations may want to put the PowerPoint on a shared drive, while others may want to burn a copy of the CD.</td>
<td>Go to MHA’s web site at <a href="http://www.mnhospitals.org">www.mnhospitals.org</a>. Click on “Priority Issues,” “Patient Safety,” then “Tools.” The toolkit can be found under the “Minnesota Wristband Color Toolkit” heading.</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>What to Do</th>
<th>Other Notes and Cues</th>
</tr>
</thead>
</table>
Acknowledgements

MHA Wristband Task Force

MHA would like to acknowledge the contributions of the MHA Patient Safety Committee and the MHA Wristband Task Force:

Stephanie Lach, Regions Hospital, St. Paul
Nora Vernon, Fairview Health Services, Minneapolis
Tana Casper, Grand Itasca Clinic & Hospital, Grand Rapids
Mary Buhl, St. Cloud Hospital

Special contributions from Sarah Henrickson, Human Factors-Quality Improvement Analyst
Mayo Clinic Rochester

Kristine Davis, North Memorial Medical Center, Robbinsdale
Jacqueline Attlesey Pries, Mayo Clinic, Rochester
Jo Marcum, St. Joseph’s Medical Center, Brainerd
Cindy Warta, St. Joseph’s Medical Center, Brainerd
Tania Daniels, Minnesota Hospital Association (MHA)

You may access the online information at www.mnhospitals.org. Click on “Priority Issues,” “Patient Safety,” then “Tools.” The toolkit can be found under the “Minnesota Wristband Color Toolkit” heading.

MHA would like to acknowledge three states that were instrumental in Minnesota’s wristband model:

• The Pennsylvania Color of Safety Task Force, and its early recognition of the need for wristband standardization and leadership in addressing this important issue.
• The Ohio Patient Safety Institute and their strategy to reduce or eliminate the use of wristbands.
• The Arizona Hospital and Healthcare Association and its implementation toolkit. Their expertise on the topic and support was instrumental with the development of this toolkit.

Other states wishing to reproduce this publication, please contact:

Barb Averyt, Program Director, Safe and Sound
Arizona Hospital and Healthcare Association, 2901 N. Central Ave, Suite 900, Phoenix, AZ 85012
Phone: 602-445-4321 Email: baveryt@azhha.org Web: http://www.azhha.org/public/quality

Sponsorship

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

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

“Patient safety is a top priority”
# Wristband Product Order Information

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

<table>
<thead>
<tr>
<th>Wristband Type</th>
<th>Color Specifications</th>
<th>Text Specifications</th>
<th>Font Style and Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Wristband</td>
<td>Red — PMS 1788</td>
<td>“ALLERGY” in Black</td>
<td>Arial Bold, 48 pt. All Caps</td>
</tr>
<tr>
<td>Fall Risk Wristband</td>
<td>Yellow — PMS 102</td>
<td>“FALL RISK” in Black</td>
<td>Arial Bold, 48 pt. All Caps</td>
</tr>
<tr>
<td>DNR Wristband</td>
<td>Purple — PMS 254</td>
<td>“DNR” in White</td>
<td>Arial Bold, 48 pt. All Caps</td>
</tr>
<tr>
<td>Restricted Extremity Wristband</td>
<td>Pink — PMS 1905</td>
<td>“RESTRICTED EXTREMITY” in Black</td>
<td>Arial Bold, 28 pt. All Caps</td>
</tr>
<tr>
<td>Latex Allergy Wristband</td>
<td>Green — Pantone Green</td>
<td>“LATEX ALLERGY” in Black</td>
<td>Arial Bold, 28 pt. All Caps</td>
</tr>
</tbody>
</table>

“Patient safety is a top priority”
**Vendor Information continued**

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Alert Wristbands</th>
<th>Part Number</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The St. John Companies</strong></td>
<td></td>
<td></td>
<td><strong>Your complete source for patient identification.</strong></td>
</tr>
<tr>
<td>25167 Anza Drive</td>
<td>Allergy</td>
<td>Red — WBCALA-5</td>
<td>The St. John Companies, Inc. is at the forefront of the standardization efforts to ensure clear patient identification and patient safety.</td>
</tr>
<tr>
<td>Valencia, CA 91355</td>
<td></td>
<td>Red Narrow — WBCNAA-5</td>
<td></td>
</tr>
<tr>
<td>Karen Joseph</td>
<td>Fall Risk</td>
<td>Yellow — WBCFRA-3</td>
<td>St. John’s products meet the recommendations for standardization in Minnesota. The following states have already implemented their color-coding initiatives and have chosen St. John as their patient ID partner: Arizona, California, Colorado, Kansas, Missouri, Nevada, New Mexico, Oregon, Utah and Wyoming.</td>
</tr>
<tr>
<td>Senior Product Manager</td>
<td></td>
<td>Yellow Narrow — WBCNFA-3</td>
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<tr>
<td>– Patient Identification/</td>
<td>DNR</td>
<td>Purple — WBCDNA-8</td>
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<tr>
<td>Patient Safety</td>
<td></td>
<td>Purple Narrow — WBCNDA-13</td>
<td></td>
</tr>
<tr>
<td>800-435-4242</td>
<td>Restricted Extremity</td>
<td>Pink — WBCREA-7</td>
<td></td>
</tr>
<tr>
<td>Fax: 661-257-2587</td>
<td></td>
<td>Pink Narrow — WBCREA-7</td>
<td></td>
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<tr>
<td><a href="http://www.patientIDexpert.com">www.patientIDexpert.com</a></td>
<td>Latex Allergy</td>
<td>Green — WBCLAA-10</td>
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<td></td>
<td></td>
<td>Green Narrow — WBCCNXA-10</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Patient Identification</td>
<td>Customization available</td>
</tr>
<tr>
<td><strong>Standard Register</strong></td>
<td></td>
<td></td>
<td><strong>Specializing in custom wristband solutions to address every hospital’s needs.</strong></td>
</tr>
<tr>
<td>P.O. Box 1167</td>
<td>Allergy</td>
<td></td>
<td><strong>Specializing in customized Training/Education Solutions (kits, binders, posters, reference cards, brochures, magnets etc.) to deliver up-to-date materials when and where you need them.</strong></td>
</tr>
<tr>
<td>Dayton, OH 45401-1167</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sherry Bannister, Label Product Marketing Manager</td>
<td>Fall Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>937-221-1299 office</td>
<td>Patient Identification</td>
<td></td>
<td></td>
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<tr>
<td>800-755-6405</td>
<td></td>
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<tr>
<td><a href="http://www.standardregister.com">www.standardregister.com</a></td>
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<tr>
<td><strong>EndurID</strong></td>
<td></td>
<td></td>
<td><strong>White laser printable wristband which can then be color-coded with any desired color using color laser printers.</strong></td>
</tr>
<tr>
<td>360 Merrimack Street, Building 9</td>
<td>Allergy</td>
<td></td>
<td></td>
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<tr>
<td>Lawrence, MA 01843</td>
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<tr>
<td>Robert Chadwick, President</td>
<td></td>
<td></td>
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<tr>
<td>866-372-6585</td>
<td>Fall Risk</td>
<td></td>
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<tr>
<td>Fax: 978-686-9710</td>
<td>Patient Identification</td>
<td>Multiple choices available</td>
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</tr>
<tr>
<td><a href="http://www.endurid.com">www.endurid.com</a></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Posey</strong></td>
<td></td>
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<tr>
<td>5635 Peck Road</td>
<td>Allergy</td>
<td>Red 6247R — Embossed with “Allergy”</td>
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<tr>
<td>Arcadia, CA 91006</td>
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<td></td>
</tr>
<tr>
<td>800-447-6739</td>
<td>Fall Risk</td>
<td>Yellow 6247Y — Embossed with “Fall Risk”</td>
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<tr>
<td>Jim Minda, District Manager</td>
<td></td>
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<tr>
<td>412-779-6667</td>
<td>Patient Identification</td>
<td></td>
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<tr>
<td><a href="mailto:minda4@comcast.net">minda4@comcast.net</a></td>
<td></td>
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<tr>
<td><strong>PDC (Precision Dynamics Corporation)</strong></td>
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<tr>
<td>13880 Del Sur Street</td>
<td>Allergy</td>
<td>Multiple choices available — Embossed with “Allergy”</td>
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<tr>
<td>San Fernando, CA 91340</td>
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<tr>
<td>Marilin Miller, SE Regional Sales Manager</td>
<td>Fall Risk</td>
<td>Multiple choices available — Embossed with “Fall Risk”</td>
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</tr>
<tr>
<td>800-847-0670</td>
<td>Patient Identification</td>
<td>Multiple choices available</td>
<td></td>
</tr>
<tr>
<td><a href="http://www.pdccorp.com">www.pdccorp.com</a></td>
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The St. John Companies

- DNR
- Allergy
- Fall Risk
- Restricted Extremity
- Latex Allergy

“Patient safety is a top priority”
The St. John Companies, Inc., an established leader in patient identification and patient safety products for the healthcare industry, was founded in 1956.

During the past 50 years, St. John has since become one of the leading manufacturers and distributors of Patient Identification, Healthcare Labels, Medical Imaging, and Medical Records products to thousands of U.S. hospitals and Alternate Care facilities.

Our Patient Identification Systems include:

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

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

The St. John Companies is at the forefront of the standardization efforts to ensure clear patient identification and improve patient safety.

St. John’s products meet the recommendations for standardization in Minnesota. The following states have already implemented their color-coding initiatives and have chosen St. John as their Patient ID partner: Arizona, California, Colorado, Kansas, Missouri, Nevada, New Mexico, Oregon, Utah and Wyoming.
Consolidate your admit and alert wristbands “In-A-Snap™!”

In-A-Snap™ Colored Alert Clasps

<table>
<thead>
<tr>
<th>Available Imprints:</th>
<th>Available Colors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Allergy</td>
<td>ORANGE</td>
</tr>
<tr>
<td>- Diabetic</td>
<td>YELLOW</td>
</tr>
<tr>
<td>- DNR</td>
<td>PINK</td>
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<tr>
<td>- Dysphagia</td>
<td>PURPLE</td>
</tr>
<tr>
<td>- Fall Risk</td>
<td>CLEAR</td>
</tr>
<tr>
<td>- Isolation</td>
<td>BLUE</td>
</tr>
<tr>
<td>- No Blood</td>
<td>GREEN</td>
</tr>
<tr>
<td>- No Latex</td>
<td>RED</td>
</tr>
<tr>
<td>- Swallow</td>
<td></td>
</tr>
</tbody>
</table>

Available Imprints: - Allergy - Diabetic - DNR - Dysphagia - Fall Risk - Isolation
Available Colors: ORANGE YELLOW PINK PURPLE CLEAR BLUE GREEN RED

Customization available, call for more information.

Our proprietary, innovative In-A-Snap™ colored alert clasp allows you to consolidate multiple wristbands while ensuring that critical alert information is visible and easily seen and understood by caregivers. In-A-Snap™ colored alert clasps can be color coded and, if desired, imprinted with the specific alert.

Communicate multiple alerts on a single consolidated wristband easily and effectively with In-A-Snap’s™ unique interleaving design.

In-A-Snap™ colored alert clasps work with a wide variety of St. John Conf-ID-ent™ patient identification wristbands.

Whether you choose to use colored alert wristbands special alert labels, or want to find a primary identification wristband that can be color coded, St. John is committed to helping you achieve your patient safety goals.

Bio-Logics

In 2005, The St. John Companies broadened its offering of patient identification solutions with the acquisition of Bio-Logics Products. The only wristband manufactured to incorporate the concept of “24/7 Patient Identification” and consolidate multiple wristbands for improved patient safety. This innovative solution provides the ability to immediately re-band patients at bedside, increasing patient safety and ensuring proper identification during their entire stay.

The Bio-Logics patient identification solution gives users the ability to combine admissions, alerts (using labels or In-A-Snap™) and blood ID into one wristband for a safer and more cost effective solution.
Our patient safety experts will work with you to determine the best way to ensure clear patient identification and patient safety. If you don’t see a solution that meets your needs, we’ll be happy to customize one for you.

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

### Admission Wristbands
- Imprint Wristbands
- Insert Wristbands
- Write-On Wristbands (Also available with clear protective covering)
- Tyvek® Wristbands
- Thermal Wristbands (Available with clasp or adhesive closure)

### Alert Wristbands
- DNR
- Allergy
- Fall Risk
- Restricted Extremity
- Latex Allergy
- Other alert wristbands available

### Blood Identification Wristbands

### Labor and Delivery Wristbands

### NICU Wristbands

### Disaster Preparedness Wristbands

### Emergency Room Wristbands

For a complete selection of patient identification wristbands, visit us online at [www.patientIDexpert.com](http://www.patientIDexpert.com)
Conf-ID-ent™ ScanRite™ Thermal Bar Code Wristbands

The ScanRite™ adhesive and clasp closure wristbands offer low cost and the ease of printing with a thermal printer. A bar code printed by a laser printer can leave toner overspray resulting in unreliable scanability. A bar code printed by a thermal printer uses heat transfer to create a crisp bar code image resulting in reliable first read rates. A thermal wristband is durable, waterproof, tamper proof, cost effective, and easy to use. Use color coded In-A-Snap™ alert clasps to consolidate alerts into one wristband, increasing patient safety and comfort while reducing the cost of multiple wristbands.

Conf-ID-ent™ Laser Bar Code Wristbands and Chart Labels

We offer the largest variety of laser wristband layouts that work with a wide variety of laser printers. Choose from a single wristband layout with or without chart labels.

Standard features include a clear fold over laminating shield to protect the integrity of the bar code, water resistant materials to reduce smearing, and pattern adhesive to reduce oozing adhesive that may cause printer jams.

Optional tamper evident closure and punched holes for filing in the patients chart are also available.

Soft Band™ Laser Wristbands

Soft Band™ laser wristbands are a patient identification choice that is perfect for your most sensitive patients’ skin. Soft Band™ is made of a resilient, super soft, fabric material that is extra strong while maintaining skin integrity. With its flat surface the Soft Band™ is easy to scan, with great first time scan rates. Available with a tamper evident adhesive or an exclusive tamper proof clasp closure. The unique design of Soft Band™ allows for a traditional or tag style application. Use color coded In-A-Snap™ alert clasps to consolidate alerts into one wristband, increasing patient safety and comfort while reducing the cost of multiple wristbands.