

Frequently Asked Questions

Improving patient safety, including reducing risks of injury or harm, is a strategic focus of the Tennessee Hospital Association (THA) through its Tennessee Center for Patient Safety (TCPS). The Tennessee Center for Patient Safety was recently designated as a patient safety organization (PSO). **The Tennessee Center for Patient Safety is engaging hospitals in an effort to improve communication and reduce the risk of patient harm through the voluntary standardization of color-coded patient alert wristbands.**

Similar initiatives are under way in more than 25 states in an effort to improve patient safety. **This endeavor is *not* meant to encourage those hospitals that presently do not use color-coded patient alert wristbands to adopt the practice.** Rather, the goal is to gain a 100 percent standardization rate among those Tennessee hospitals that currently use color-coded patient alert wristbands, ensuring the consistency of three alerts: allergy (red), fall risk (yellow) and do-not-resuscitate (purple).

Questions & Answers

Q: The hospital has never used color-coded patient alert wristbands. Should we start?

A: No. THA does not encourage hospitals to start using color-coded patient alert wristbands if they do not already use them. The standardization initiative is directed only to those hospitals/health systems that currently use color-coded patient alert wristbands in order to reduce preventable medical errors caused by lack of consistency in alert messages provided to caregivers.

Q: Why is THA leading an initiative to standardize color-coded patient alert wristbands?

A: The purpose of the initiative is to consistently and effectively communicate an alert to a healthcare provider if the patient has an allergy, is a fall risk and/or carries a do-not-resuscitate (DNR) order. With a standardized method of communicating these risks, the potential for confusion when patients, physicians and nurses travel between different hospitals is greatly reduced.

Q: How long will it take to standardize color-coded patient alert wristbands?

A: The process is unique for each hospital and can take several months. Our target for Tennessee is for facilities to complete this standardization by Dec. 31, 2009.

Q: What colors were chosen for standardization?

A: As of summer 2009, nearly 30 states have standardized color-coded patient alert wristbands. Consistent with these states and the American Hospital Association, the Tennessee Center for Patient Safety is implementing a color-coded patient alert wristband standardization initiative focused on the three most commonly used patient alert wristband colors: red to indicate allergy, yellow to indicate fall risk and purple to indicate do-not-resuscitate (DNR).

Q: What is the first step in pursuing standardization?

A: Members will be provided educational tools for conducting this standardization. These toolkits contain numerous sample communications and materials that inform hospitals about how best to carry out the standardization. This toolkit will be available online and the TCPS staff will be available throughout the process to answer questions.

Q: Do color-coded patient alert wristbands infringe on patient privacy and/or violate the Health Insurance Portability and Accountability Act (HIPAA)?

A: The use of color-coded patient alert wristbands does not violate HIPAA. Incidental release of patient information is allowed when necessary for hospital operations. The use of the color-coded patient alert wristbands falls under this allowed limited release of patient information.

Q: Why was purple selected for do-not-resuscitate (DNR)?

A: As other states considered the adoption of the standardized colors, there was a concern that using the color blue may cause confusion when responding to a code. Based on a survey of Tennessee hospitals, many hospitals call a “code blue” for cardiac arrest. Having a blue DNR wristband to indicate “no code” could easily cause confusion. To avoid creating any second guessing about whether to call a code in this critical moment, blue was not used.

Furthermore, the color green was avoided due to color blindness concerns. The color green also often has a “go ahead” connotation, such as with traffic lights. The possibility of sending mixed messages in a critical moment must be avoided.

Due to these reasons and to achieve consistency with the majority of states standardizing patient alert wristbands, Tennessee selected purple for DNR alert designation.

Q: If the hospital adopts the purple do-not-resuscitate (DNR) wristband, do staff members still need to look in the chart?

A: Yes. Some hospitals do not use wristbands to alert clinicians of an advance directive because they want the clinicians to review the medical record for the patient's most current code designation. A medical record should always be reviewed for the patient's most current code designation. Code status can change throughout a hospitalization, and it is important to know the current status, so the patients' and/or families' wishes can be honored.

Q: Why was red selected for allergies?

A: Research of other industries indicates that red has an association that implies extreme concern. The American National Standards Institute (ANSI) has designated certain colors as signifying very specific warnings. ANSI uses red to communicate "stop!" or "danger!" It is believed this message also would translate when communicating an allergy status. When caregivers see a red allergy alert wristband, they would likely be prompted to stop and double-check if the patient is allergic to medications, food or the treatment about to be delivered.

Q: Should the patient's allergies be written on the allergy wristband?

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

- Legibility may hinder the correct interpretation of the allergy listed.
- It could be assumed that the list of allergies written on the alert wristband is all-inclusive. However, space is limited on a wristband and some patients may have several allergies. The risk of writing on the wristband is some allergies would be inadvertently omitted due to lack of space, which can lead to confusion or an assumption that the list is comprehensive.
- Throughout a hospitalization, allergies may be discovered by other caregivers, such as dietitians, radiologists, pharmacists, etc. This information is typically added to the medical record and not always on a wristband. By having one source of information to reference, such as the medical record, staff members in all disciplines know where to add and review newly discovered allergies.

Q: Why was yellow selected for fall risk?

A: Research indicates yellow implies "caution," such as the last color warning before a stop at a traffic light. In addition, the American National Standards Institute uses yellow to communicate "tripping or falling hazards." The color yellow would alert caregivers to use caution with a patient who has a history of falls, dizziness and difficulty with balance, fatigue or dementia.

Q: Why use an alert band for fall risk?

A: When a patient is wearing a fall risk alert wristband, it notifies all hospital staff that the patient needs to be assisted when walking or getting up from a sedentary position. According to the Centers for Disease Control and Prevention (CDC), falls are of great concern for the aging American population. According to the CDC:

- More than one-third of adults age 65 or older fall each year.
- Older adults are hospitalized for fall-related injuries five times more often than for injuries resulting from other causes.
- Of those adults who fall, 20 to 30 percent suffer moderate to severe injuries that reduce mobility and independence and increase the risk of premature death.
- The total cost of all fall injuries for people age 65 or older in 1994 was more than \$27 billion.
- By 2020, the total cost of fall injuries is expected to reach more than \$44 billion. Hospital admissions for hip fractures among people over age 65 have increased steadily from 230,000 admissions in 1988 to 338,000 admissions in 1999.
- The annual number of hip fractures is expected to exceed 500,000 by the year 2040. As the aging population enters the acute care environment, the risk that is present must be considered, and everything possible should be done to communicate that risk to staff. For more information about falls and related statistics, visit www.cdc.gov/ncipc/factsheets/fallcost.htm.

Q: Who chose these colors?

A: The Tennessee standardization initiative is modeled after the original work done by the Pennsylvania Color of Safety Task Force, Arizona Hospital and Healthcare Association and the experiences of other states that have adopted standardized colors for patient alert wristbands. The American Hospital Association also has adopted these wristband colors and patient alert meanings.

Q: Can hospitals still use other colors for additional alert messages?

A: THA's standardization efforts mirror the national consensus and AHA recommendations. Hospitals should attempt to limit the number of colored bands used to high alert messages--the more colors used, the higher risk for confusion. If additional colored wristbands are used, pink is suggested for "restricted extremity" and green for "latex allergy."

Q: Our hospital only uses wristbands for two of the alerts- allergy and falls. We don't use wristbands for DNR. Can we participate without adopting all three alerts?

A: Yes. Hospitals are encouraged to use the standardized colors and meanings for the wristband alerts they currently use in their organization. If a hospital uses only one or two of the alerts, they do not have to add additional wristband alerts.

Q: What if a hospital uses red for blood bank wristbands too?

A: Some hospitals are currently using red wristbands for blood bank information which generally contain important patient identification information and blood specifications. Under Tennessee wristband standardization guidelines, a red allergy wristband contains no other text than the word “allergy”. Other than the color, the wristbands do not have similar characteristics and would be difficult to confuse. If a clinician is searching for blood bank information, it will not appear on an allergy wristband, prompting the clinician to look for a blood band wristband or locate the patient’s medical record. If a clinician notices a blood bank wristband and questions whether it indicate an allergy, the clinician should follow best practice and refer to the patient’s medical record to verify what, if any, allergies the patient may have. Each individual hospital should decide on the most appropriate course of action for their facility’s needs.

Q: In our community chronic kidney disease clients wear red-orange rubber wristbands that say “Save the Vein-No IV/Lab Sticks”. Should these be removed for acute care admissions?

A: Care should be taken to note the restricted extremity and document the need for restricted extremity access on assessment in accordance with your organization’s policies and procedures. It is recommended that these community wristbands be removed during any acute care inpatient admission and the wristband returned to the patient/family in keeping with the Tennessee color-coded wristband alert initiative recommendations. There is a high-risk of confusion between these restricted extremity alert bands and the hospitals’ standardized use of red color-coded wristbands for allergy alerts. If hospitals use color-coded wristbands for “restricted extremity”, pink is the recommended color.

THA Staff Contacts

Members with questions regarding the various activities related to wristband standardization should contact one of the following THA staff members:

Color-Coded Patient Alert Wristband Standardization:

Chris Clarke
cclarke@tha.com
(615)401-7437

Darlene Swart
dswart@tha.com
615-401-7460

Media:

Beth Atwood
batwood@tha.com
(615) 256-8240