Standardization of Color-Coded Patient Alert Wristbands

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Purpose Statement

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

Background

In 2005, a hospital in Pennsylvania submitted a report to the Pennsylvania Patient Safety Reporting System describing an event in which clinicians nearly failed to rescue a patient who had a cardiopulmonary arrest because the patient had been incorrectly designated as “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, another clinician identified the mistake, and the patient was resuscitated.

Endorsed by the American Hospital Association for nation-wide adoption, over 37 states have adopted a standardized set of colors for patient alert wristbands. The United States Army Medical Command (MEDCOM) published a policy directing Army Medical Treatment Facilities (MTFs) to implement a minimum of 5 standardized colors for patient alerts. These patient safety and quality concerns led to an examination of color-coded wristbands at this military hospital.

Method

- A literature review provided evidence in support of standardizing color-coded patient alert wristbands.
- An audit of current use of patient alert wristbands was conducted throughout the hospital and outpatient clinics.
- A local policy developed to address standardization of the color of the alert wristband also included application of wristbands, patient/family education, staff education, and hand-off communication for transfers within the facility or to another health care setting.
- An electronic medical record update allows for documentation of alert wristbands in use for the patient.
- Purchasing and stocking of wristbands in unit Point-of-Use cabinets was coordinated with the Logistics Department and implementation synchronized with staff and patient education.

Results

The audit demonstrated limited standardization of alert wristbands throughout the facility.
- Wristbands of the same color were used in different areas for different purposes.
- In some cases, allergies handwritten on wristbands were misspelled, illegible or incomplete.
- Six different types of white patient identification bands were found in both inpatient and outpatient areas.

Standardization of patient identification and color-coded alert wristbands in our facility has decreased the risk for medical error.

Conclusions

Adoption of standardized colors for patient alert wristbands promotes quick identification of patients at risk and decreases the risk of medical error.

The views expressed are those of the authors and do not reflect the official policy of the Department of the Army, the Department of Defense or the U.S. Government.

The title slide of the presentation includes the following information:

- Standardization of Color-Coded Patient Alert Wristbands
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The slide also contains a diagram illustrating the process of standardizing color-coded wristbands, with steps such as:
- What to tell patients or family about the color-coded wristbands
- Color-Coded "Alert" Wristband/Risk Reduction Strategies
- Staff Education Regarding: Standardization of Color-Coded Alert Wristbands
- PATIENT SAFETY FIRST!
- Understanding Your Color-Coded Alert Wristband
- PATIENT SAFETY: What Do the Different Colors Mean?
- PENN means Restricted Extremity
- RED means Allergy Alert
- GREEN means Latex Allergy
- ORANGE means Memory Alert

The presentation suggests that the authors have conducted research and have implemented changes to improve patient safety and reduce medical errors.