



Standardizing Color Codes for Patient Risk Factors



*A Safety Initiative from
the New Jersey Department of Health and Senior Services
and the New Jersey Hospital Association*

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Color-coded wristbands are used in an array of hues to communicate numerous conditions such as fall risk, allergies, DNR, restricted extremity, elopement risk and dietary restrictions. Colored-cause wristbands, such as the yellow “Live Strong” bands can be misinterpreted as a hospital-issued color-coded condition wristband. The availability of numerous cause wristbands, coupled with varying definitions of patient alert bands across the continuum of care can be confusing for caregivers and threaten patient safety.

Although we do not endorse the exclusive use of wristbands to alert caregivers of a patient’s special needs, providers do agree that when used, there is a lack of consistency in wristband meanings and in how they are applied. In New Jersey, the New Jersey Hospital Association, in partnership with the New Jersey Department of Health and Senior Services, initiated an effort to standardize communication for patient risk factors and special needs before patient harm occurs.

Bringing together industry experts, the initiative defines a standard set of colors to indicate a defined set of risks. It also seeks agreements among a broad range of healthcare providers to use these colors. The effort included the involvement of healthcare providers and facilities across the continuum of care including all types of hospitals, long term care facilities, ambulatory centers and home health providers, as well as the professional organizations representing the facilities and the professions involved. This expert panel:

1. Identified the priority risk categories for patients across the continuum of care
2. Reached consensus on standardized color definitions of wristbands
3. Developed a work plan and created a Startup Implementation Kit for providers to use to adopt the standardization of color coded wristbands
4. Initiated implementation of the standardized colors using the Startup Implementation Kit

A SNAPSHOT OF NEW JERSEY’S COLORS

April 2007 survey results from approximately 75 providers of care, including acute care hospitals (designated as “acute”), specialty hospitals, long term care, assisted living facilities, and home health agencies (designated as “other”), reflect a variety of colors and means of communicating patient risk factors, including colored wristbands, stickers and signage. In the acute care setting, ten different colors (including white and clear) designate 19 different risk factors, while in our other settings, an assortment of nine colors represent approximately 25 different risks.



RED PATIENT HIGH RISK WRISTBANDS

Of particular note, red wristbands have been used to designate eight different patient risks in the acute care setting, while other providers commonly choose from four different colors.



ALLERGY

Taking into consideration the six patient identifiers most often endorsed nationally New Jersey has similar results in variety.



FALL RISK



LATEX ALLERGIES



DNR



RESTRICTED LIMB



SO WHAT IS NEW JERSEY'S LANDSCAPE OF COLOR?

RISK FACTOR	PURPLE	BLUE	TEAL	GREEN	RED	PINK	ORANGE	YELLOW	WHITE	CLEAR
ALLERGY										
FALL										
LATEX										
DNR										
RESTRICTED EXTREMITY										
TAPE ALLERGY										
PROCEDURE SITE										
BLOOD TYPE										
BLOOD BANK ID										
NO BLOOD PRODUCTS										
OP OR ER PATIENT										###
PEDS/MOTHER/CHILD										
PARENT/GUARDIAN										
SIMILAR NAME										
OBSERVATION										
ISOLATION										
ELOPEMENT										
PACEMAKER										
ANTICOAGULANTS										
NPO										
DIETARY RESTRICTIONS										
DIABETES										
CHF										
CARDIAC										
AICD										
SEIZURE										
DYSPHAGIA										
LACTATING WOMAN										
BRAIN INJURY										
THICKENED LIQUID										
INPATIENT										
BLOODLESS PATIENT										
2 PERSON TRANSFER										
MECHANICAL DIET										
AVOID BLOOD										
NUCLEAR MED TEST										
FULL CODE										
HONEY THICK LIQUID										
NECTAR THICK LIQUID										
TRAUMA										
PROBLEM CARE PLANS										
OUTPATIENT										

Although many providers communicate alerts by using wristbands, door, wall or bed signage and transport vehicle tags, means of patient, family and community education is limited to brochures in most instances. Few providers utilize video or other form of media.

Implementation and Staff Education Training Tips

INTRODUCTION

This section regarding policy development and staff education has been designed knowing that not all facilities will decide to implement this model in its entirety. The goal was to make this section comprehensive without being overly burdensome. Make this plan work for you - use what you want and remember that the goal is to communicate the changes with color-coded wristbands to staff in a way that is meaningful and meets the needs of your organizational culture.

Is this a mandatory program for all providers in New Jersey?

The decision to standardize color-coded wristbands according to this statewide initiative is a decision that needs to be made within your organization. This voluntary initiative was implemented based on the significant variation in alerts that are used throughout the continuum of care. It can and should be implemented in a way that best fits the culture of your organization. NJDHSS and NJHA suggest staff meetings, education sessions, new employee orientation and evaluation of annual competencies to reinforce the new alert protocols.

KEY PREPARATION BEFORE YOU BEGIN

Be sure to include all your stakeholders in the planning and implementation process. Consider everyone — all those who are impacted — in this system change.

STAKEHOLDERS TO CONSIDER

Committees such as

FOR ACUTE CARE HOSPITALS -

- Patient Safety Committee
- Medical Staff and Medical Staff Executive Committees
- Nurse Practice Council
- Performance Improvement Committee
- Board of Directors
- Operating Room Committee
- Emergency Department Committee

FOR POST-ACUTE CARE FACILITIES -

- Resident Safety Committee
- Physician & Nursing Related Committees
- Performance Improvement Committee
- Board of Directors
- Pharmacy & Therapeutics
- Risk Management

DEPARTMENTS SUCH AS -

- Materials Management
- Staff Education
- Risk Management
- Quality Improvement
- Medical Staff
- Admitting
- Nursing Operations
- Dietary
- Housekeeping / Environmental Services
- Laboratory
- Radiology
- Pharmacy
- Emergency Department
- OR/PACU
- Ambulatory Patient Areas
- Transportation

THOUGHTS TO CONSIDER

1. Include everyone involved in the system of care process.
2. Environmental Services staff are often present in a patient/resident/client room when a patient/resident/client is trying to get up or is walking to the bathroom. If they know a yellow wristband means “Fall Risk,” and they see a patient/resident/client trying to get up, they can call the nursing staff, alert them and potentially prevent a fall.
3. Consider the dietary technicians. A red wristband means there is an allergy — and not just to medications. A red band will alert dietary staff to check a patient’s/resident’s/client’s profile for potential food allergies.
4. All medical staff, including attendings, intensivists, hospitalists, residents and interns, should be included in the change process.

GETTING STARTED

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 achieve compliance. A story gives them information that makes the request relevant so that they understand the importance and want to comply.

In recent months, there has been an increased awareness of potential confusion associated with the use of color-coded wristbands that identify patient/resident/client safety risks. Healthcare organizations in other states are initiating grassroots efforts to address this growing concern. Most recently, a group of Pennsylvania hospitals introduced The Color of Safety — a voluntary patient safety standardization initiative - in response to events reported to the Pennsylvania Patient Safety Reporting System. In one report, clinicians nearly failed to resuscitate a patient because she was incorrectly identified “DNR” by a nurse who worked in multiple facilities where the colors had different meanings. Fortunately, another clinician quickly identified the error and the patient was resuscitated.

This is a true story and this hospital should be commended for their transparency and disclosure of this event. It could have happened anywhere — including New Jersey — and it served as a wake up call to many.

FOLLOW THE STORY WITH DATA RESULTS - Sharing with staff how New Jersey’s practices differ not only across the continuum of care, but within our own network of providers, makes the information more relevant, and reinforces the importance of the need to standardize.

The risk for error is obvious. This initiative starts with the alerts most often used in New Jersey.

THE BIG PICTURE - Many of our caregivers work for multiple healthcare providers. Our patients/residents/clients oftentimes move throughout the continuum of care, coming to us with alert bands from a sending facility.

This initiative is being adopted by many providers of care across the continuum, throughout the state of New Jersey. Similarly, many states are embarking on standardizing the use of patient/resident/client risk alerts. We have chosen the following colors:

■ RED - ALLERGY

■ YELLOW - FALL RISK

■ GREEN -LATEX ALLERGY

■ PURPLE - DNR

■ PINK - RESTRICTED LIMB

CLEAR OR WHITE BANDS SHOULD BE USED FOR PATIENT/RESIDENT/CLIENT IDENTIFICATION.

**If providers, such as home health agencies and assisted living providers, do not use wristbands with their clients, we recommend the use of color-coordinated charts, care plan and information stickers to designate risks.*

DID YOU KNOW ?

In a 2007 survey, providers of care reported that they used the color red to designate eight different patient/resident/client risks? Allergies were identified by up to three different colors, fall risk by seven, latex allergies by five, restricted limb by five, and DNR by six!

In total, 10 different colors were used in the acute care setting to designate 19 different risk factors, while in specialty hospitals, “nursing homes, long term acute care, assisted living facilities and home health agencies providers generally used nine different colors to represent approximately 25 different risks!

FAQs ABOUT THE INITIATIVE

Research about why New Jersey initiated this voluntary program, the colors that were chosen, and the human association with those colors, is important for staff to understand so that they can feel confident with this initiative. Using the FAQs provided to encourage interactive discussion will make the training more interesting and re-engage participants in any re-training you provide.



HANDOUT - FAQ

Why do we use color-coded wristbands?

Color-coded wristbands are used in care settings to quickly communicate a certain healthcare state, condition or an “alert” that a patient/resident/client may have. This is done so every staff member can provide the best care possible.

■ **RED - ALLERGY** Red means stop! Caregivers will be alerted to stop and check the medical record and will the patient/resident/client to confirm what the allergy risk.

■ **YELLOW - FALL RISK** Yellow is a warning to slow down, pay attention and take special precautions. We want to prevent falls at all times. Nurses review patients/residents/clients all the time to determine if they need extra attention to prevent a fall. Sometimes a person may become weakened during an illness or because they just had surgery. When a patient/resident/client has this color-coded alert wristband, the nurse is saying that this person needs to be assisted when walking or transferring to help prevent a fall.

■ **GREEN - LATEX ALLERGY** Green is the color of nature. Latex comes from the liquid in tropical rubber trees. We want to assure a safe environment for our patients/residents/clients, and it can be as simple as using latex-free products.

■ **PURPLE - DNR or DO NOT RESUSCITATE** A survey indicated that most providers in New Jersey use purple to alert that there is a DNR on the chart. It is important that we honor a patient’s/resident’s/client’s wishes for end-of-life care.

■ **PINK - RESTRICTED LIMB** Pink is being used across the country to designate that care givers should be aware of a restricted limb. Sometimes a patient’s/resident’s/client’s arm shouldn’t be used for taking a blood pressure reading, drawing blood or inserting an IV because they have a shunt, PICC line or other medical reason. This band tells us to double-check to be sure that we use the correct arm.

Do we still need to look in the chart even if there is a wristband?

Always check the chart! Wristbands are merely an alert. The patient’s status can change throughout their stay, and it is important to always refer to the chart for the most current risk designations.

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.

1. Use wristbands that are pre-printed with text that tells what the band means.
2. Remove any “Social Cause” (such as Live Strong, Cancer, etc.) colored wristbands.
3. Remove wristbands that have been applied from another facility if they are not using the same color scheme. If the colors are the same, the bands can remain on.
4. Initiate banding upon admission, changes in condition or information received during the stay. Document changes in condition or information received in the medical record.
5. Educate patients/residents and family members regarding the purpose and meaning of the wristbands.
6. Coordinate chart/white board/care plan/door signage information/stickers with the same color coding as the wristbands.
7. Educate staff to verify patient/resident/client color-coded wristbands upon assessment, hand off of care and facility transfer communication.

And remember ...

When possible, limit the use of colored wristbands ... the wristband is a tool to communicate an alert status! Too many will dilute their role and staff sensitivity to their importance.

PEDIATRIC WRISTBANDS

If the 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.



POLICY DEVELOPMENT

Be sure that the policies that you develop include key points similar to those listed below. Reinforcement of the policy with staff is an important part of the education. Handout - Provider Policy

- How are we defining the colors and how do they differ from current practice?
- Who can apply the wristband to the patient/resident/client?
- When does the application of the color-coded wristband occur?

- What should be done if a patient/resident/client is wearing a “social cause” band?
- How do we educate and communicate the information with patients/residents/clients and families?
- When do we re-apply a wristband?
- How do we incorporate this information into handoff communication?
- What do we do if a patient/resident/client refuses to comply?
- How do we incorporate the color-coded wristbands into our Discharge Instructions for home or facility transfer?

TEACHING PATIENTS/RESIDENTS/FAMILY MEMBERS

We all know that how we say something is just as important as what we say. Patients/residents/clients and their loved ones are often scared, vulnerable and unfamiliar with our organizations’ ways and can be overwhelmed while in our care. It is important to communicate to them in a respectful and simple way without being condescending.

The text below is a sample “script” for staff so all can be delivering the same information to patients/residents/clients and families. By having a consistent message, we reinforce the information — this helps patients/residents/clients and families retain the information, having a sense of confidence in the healthcare system as we all communicate consistent information.

WHAT DO THE COLORS MEAN?

There are five different colors. We’ve chosen them because they are the most commonly used alerts.

RED - ALLERGY If you or your loved one has an allergy to anything, including food, medicine, dust, anything, please tell us. It may not seem important to you, but it could be very important in the care you or your loved one receives.

YELLOW - FALL RISK We want to prevent falls at all times. Nurses review patients/residents/clients all the time to determine if they need extra attention to prevent a fall. Sometimes a person may become weakened during an illness or because they just had surgery. When a patient/resident/client has this color-coded alert wristband, the nurse is saying

that this person needs to be assisted when walking or transferring to help prevent a fall.

GREEN - LATEX ALLERGY If you are allergic to latex, there are alternative products that can be used by caregivers. We want to assure a safe environment for our patients/residents/clients, and it can be as simple as using latex-free products.

PURPLE - DNR or DO NOT RESUSCITATE It is important that we honor a patient’s/resident’s/client’s wishes for end-of-life care.

PINK - RESTRICTED LIMB Sometimes a patient’s/resident’s/client’s arm shouldn’t be used for taking a blood pressure reading, drawing blood or inserting an IV because they have a shunt, PICC line or other medical

reason. This band tells us to double-check to be sure that we use the correct arm.

HANDOUT - We Suggest Sample Wristbands For Use In Training

**If providers, such as home health agencies and assisted living providers, do not use wristbands with their clients, we recommend the use of color coordinated charts, care plan and information stickers to designate risks.*

WHY DO WE USE COLOR-CODED WRISTBANDS?

Color-coded wristbands are used in care settings to quickly communicate a certain healthcare state, condition or an “alert” that a patient/resident/client may have. This is done so every staff member can provide the best care possible.



SAMPLE POLICY AND PROCEDURE LANGUAGE

PURPOSE

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

OBJECTIVES

- A. To reduce the risk of potential for confusion associated with the use of color-coded wristbands;
- B. To communicate patient/resident/client safety risks to all health care providers;
- C. To include the patient/resident/client, family members and significant others in the communication process;
- D. To promote safe healthcare; and
- E. To adopt the following risk-reduction strategies:
 - a. A preprinted written descriptive text is used on the bands clarifying the intent (i.e., “Allergy,” “Fall Risk,” “Latex Allergy,” “DNR” or “Restricted Limb”);
 - b. Restrict the use of handwriting on the color-coded wristband, except in emergent situations;
 - c. Application or removal of color-coded wristbands will occur only by a nurse or licensed staff person conducting an assessment;
 - d. Labels, stickers or other visual cues will be used in the medical record to communicate risk factors or color-coded wristband application, using the same corresponding color and text associated with the colored band;
 - e. “Social cause” wristbands, such as the “Live Strong” and other causes, should not be worn by patients/residents in the healthcare setting. Staff should have family members take the social cause wristbands home or remove them from the patient/resident/client and store them with their other personal items. This is to avert confusion with the color-coded wristbands and to enhance patient/resident/client safety practices; and
 - f. To assist the patient/resident/client and their family members in becoming a partner in the care provided and safety measures being used, patient/resident/client and family education should be conducted regarding:
 - i. The meanings of the color-coded wristbands and the alert associated with each wristband; and
 - ii. The risks associated with wearing “social cause” wristbands and why patients/residents are asked to remove them.

DEFINITIONS

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

REDALLERGY

YELLOWFALL RISK

GREENLATEX ALLERGY

PURPLEDO NOT RESUSCITATE (DNR)

PINKLIMB ALERT

Identification (ID) Bands in Admission, Pre-Registration, Emergency or Outpatient Departments:

Colorless (clear) admission patient/resident identification wristbands are applied in accordance with procedures outlined in organizational policy on patient/resident identification and registration.

COLOR-CODED WRISTBANDS

During the initial patient/resident/client assessment, data is collected to evaluate the needs of the patient/resident/client, and a plan of care unique to the individual is initiated. Throughout the course of care, ongoing reassessment may uncover additional pertinent medical information, trigger key decision points or reveal additional risk factors about the patient/resident/client. It is during the initial and reassessment procedures that risk factors 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/resident/client demonstrating risk factors on initial assessment will have a color-coded wristband placed on the same extremity as the admission identification band by the nurse or licensed professional if the nurse is unavailable.
- B. The application of the color-coded wristband is documented in the chart by the nurse [per provider policy].
- C. If labels, stickers or other visual cues are used to document in the record, the stickers should correspond with wristband color and text.
- D. Upon application of the color-coded wristband, the nurse will instruct the patient/resident/client and family members, 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.

SOCIAL CAUSE WRISTBANDS

Following the identification process, a licensed clinician, such as the admitting nurse, examines the patient/resident/client for “social cause” wristbands.

If social cause wristbands are present, the nurse will explain the risks associated with the wristbands and ask the individual to remove them. If the patient/resident/client agrees, the band will be removed and given to a

family member to take home or stored with the other personal belongings. If the patient/resident/client refuses, the nurse will request that a refusal form acknowledging the risks associated with the “social cause” wristband (see attached document) be signed. In the event that the patient/resident/client is unable to provide permission and family members or a significant other is also not present, the licensed staff member may remove the band or cover the band with tape or gauze to reduce the potential of confusion or harm.



PATIENT/RESIDENT/CLIENT/FAMILY INVOLVEMENT AND EDUCATION

It is important that the patient/resident/client and family members are informed about the care being provided and the significance of that care and that they are acknowledged as valuable members of the healthcare team. Including them in the process of color-coded wristbands will assure a common understanding of what the bands mean, how care 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/resident/client and family members about:

- A. The meanings of the color-coded wristbands and the alert associated with each;
- B. The risks associated with wearing “social cause” wristbands and why they are asked to remove them;
- C. The importance of notifying the nurse whenever a wristband has been removed and not reapplied; or
- D. The importance of notifying the family when and for what reason a new band is applied.

Patients/residents/clients and families have an educational brochure available to them that explains this information as well.

HAND-OFF COMMUNICATION

The nurse will reconfirm with patient/family/client, other caregivers and the patients chart at transfer and during changes in level of care that color-coded wristbands are appropriate. Errors are corrected immediately and documented.

Color-coded wristbands are not removed at discharge. For home discharges, the patient/resident/client 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 follow their policy and procedure for the banding process.



DO NOT RESUSCITATE (DNR)

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

STAFF EDUCATION

Staff education regarding color-coded wristbands should occur during the new orientation process and reinforced as appropriate. [Providers should insert specific language so it matches annual processes and competencies, should you decide to include color-coded wristbands in that process.]

PATIENT/RESIDENT/CLIENT REFUSAL

If the patient/resident/client refuses to wear the color-coded band, or refuses to remove a “social cause” wristband, an explanation of the risks will be provided. 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 healthcare team. The nurse will document refusals in the medical record and the explanation provided by the patient/resident/client or their family member. The patient/resident/client will be requested to sign an acknowledgement of refusal.

(Insert Identification Information Per Provider Policy)

PATIENT/RESIDENT/CLIENT REFUSAL TO PARTICIPATE IN WRISTBAND PROCESS

The above named individual refuses to wear color-coded alert wristbands.

- The benefits of the use of color-coded wristbands have been explained to me by a member of my healthcare 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.
- 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” wristband could cause confusion in my care, and despite this information, I do not give permission for the removal or covering with tape or gauze of the “social cause” colored wristband.

Reason provided (if any)

Date

Time

Signature

Relationship

Date

Time

Witness Signature

Job Title

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