Standardization of Color-Coded Patient Alert Wristbands

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**Purpose:** 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/Significance:** 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 nationwide 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.

**Description:** A literature review was conducted providing 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 was developed to address standardization of the color of the alert wristband, application of wristbands, patient/family education, staff education, and hand-off communication for transfers within the facility or to another health care setting. The electronic medical record was updated to allow 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 was synchronized with staff and patient education.

**Evaluation and Outcomes:** 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.

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