“Patient safety is our first priority”
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Executive Summary

“Patient safety is our first priority”
Most of us can imagine this type of near miss occurring in any institution. Consider these statistics regarding hospital staff:

- New staff – Kansas hospitals reported an RN vacancy rate of 8.8 (2007)
- The same survey reports hospital turnover rate for RNs as 12% (2007)
- Many hospitals in the state are using agency and traveler RNs to staff vacant positions

The potential for confusion is obvious, significant, and avoidable.

In August 2007, KHA surveyed its member hospitals regarding their use of patient wristbands. The results showed that Kansas hospitals were using 39 different wristband colors to represent patient status categories. For DNR status alone, 10 different colors were being used with 8 colors used for fall risk. The good news was that all hospitals responding to the survey indicated that they would be willing to adopt a standardized wristband color-coded system.

In December 2005, a patient safety advisory was issued from the Pennsylvania Patient Safety Reporting System that received national attention. This advisory brought to surface an incident that occurred in a hospital 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 confusion was a nurse that had incorrectly placed a yellow wristband on the patient. In that hospital a yellow wristband meant DNR. In a nearby hospital, where the nurse also worked, yellow meant “restricted extremity” which was what she wanted to alert staff about. Fortunately in this case, another nurse recognized the mistake and the patient was resuscitated.

The potential for confusion is obvious, significant, and avoidable.

In August 2007, KHA surveyed its member hospitals regarding their use of patient wristbands. The results showed that Kansas hospitals were using 39 different wristband colors to represent patient status categories. For DNR status alone, 10 different colors were being used with 8 colors used for fall risk. The good news was that all hospitals responding to the survey indicated that they would be willing to adopt a standardized wristband color-coded system.

Figure 1: Color-coded Wristbands
What color wristband do you use for “DNR?”
N= 61

<table>
<thead>
<tr>
<th>Color</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Band</td>
<td>51%</td>
</tr>
<tr>
<td>Blue</td>
<td>21%</td>
</tr>
<tr>
<td>Blue Dots</td>
<td>4%</td>
</tr>
<tr>
<td>Red Dots</td>
<td>3%</td>
</tr>
<tr>
<td>Green</td>
<td>3%</td>
</tr>
<tr>
<td>Red</td>
<td>2%</td>
</tr>
<tr>
<td>White</td>
<td>1%</td>
</tr>
<tr>
<td>Orange</td>
<td>1%</td>
</tr>
<tr>
<td>Green Dots</td>
<td>1%</td>
</tr>
<tr>
<td>Orange Dots</td>
<td>1%</td>
</tr>
<tr>
<td>Pink Dots</td>
<td>1%</td>
</tr>
</tbody>
</table>

Ten different colors/methods are being used throughout Kansas to convey DNR status.
Executive Summary continued

In 2008, the KHA Quality and Patient Safety Technical Advisory Group and the KHA Council on Health Delivery reviewed the results of the survey and came to a consensus. Both groups recommended that the Arizona model be used to standardize color-coded wristbands in Kansas. In addition, they suggested adding two optional colors; PINK to indicate restricted extremity and GREEN to indicate latex allergy.

In March 2008, the KHA Board of Directors approved a recommendation for Kansas hospitals to use a 3-5 color patient wristband standardization program. Hospitals should have programs in place by January 1, 2009.

The information that follows in this kit will guide your organization through:

1. The colors for the alert designation and logic for the colors selected
2. Work plan for implementation
3. Staff education including competencies
4. FAQs for general distribution
5. Sample policy and procedure
6. Vendor information for easy adoption of the recommendation
7. Patient education brochure

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. This effort will require a willingness to change for the greater good. Some hospitals will have a minor change while others may have a major change. We realize that change is difficult; we also realize that change made for reasons that benefit the safety of your staff, your loved ones and your communities are changes for all the right reasons.

“Patient safety is our first priority”
Recommendations for Adoption

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

"Patient safety is our first priority"
Recommendations for Adoption – June 2008

**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 or clasp, “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. Registry and traveler 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.** We don’t use wristbands for DNRs at this hospital. Why should we consider adopting this?

**A.** Wristbands are used in many Kansas hospitals to communicate an alert. Registry staff, travelers, non-clinical staff, etc. may be unaware of where to look in the medical record if they are new to your hospital. By having a wristband on, a quick warning is communicated so anyone could know about this alert. Additionally, it is also a means to communicate to the family that we are clear about their end of life wishes. By not having a band on, errors of omission could potentially be created.

**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.

“Patient safety is our first priority”
Q. So, if we adopt the purple DNR wristband then do we still need to look in the chart?

A. Yes. Some hospitals do not use wristbands for DNRs because they want the chart to be reviewed first for the most current code designation. However, that practice should be the practice in all cases - whether a wristband is being used or not. Code status can change throughout a hospitalization. It is important to know the current status so the patient's and families wishes can be honored.

Calling CODE BLUE!

Is used by 67% of Kansas hospitals to call a code team.

If Kansas selected the color blue for the DNR wristband, the potential for confusion exists.

“Does blue mean I code or I do not code?”

“Patient safety is our first priority”


**Recommendations for Adoption – June 2008**

**Allergy Alert**

**Recommendation:**

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

**FAQs**

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

A. Red was selected due to the results of an August 2007 survey conducted with Kansas hospitals that indicated two out of three hospitals already use the color red. It just made sense to continue with an established color.

**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 band they are prompted to “STOP!” and double check if the patient is allergic to the medication, food, or treatment they are about to receive.

**Q.** Do we write the allergies on the wristband too?

A. It is our recommendation that allergies be written in the medical record according to your hospital’s policy and procedure. We suggest allergies not be written on the wristband for several reasons:

1. Legibility may hinder the correct interpretation of the allergy listed;

2. By writing allergies on the wristband someone may assume the list is comprehensive. However, space is limited on a wristband and some patients have in excess of 12 or more allergies. The risk is that some allergies would be inadvertently omitted – leading to confusion or missing an allergy;

3. Throughout a hospitalization, allergies may be discovered by other caregivers, such as dieticians, radiologists, pharmacists, etc. This information is typically added to the medical record and not always a wristband. By having one source of information to refer to, such as the medical record, staff of all disciplines will know where to add newly discovered allergies.

**Quick Adoption**

By adopting red for allergy alert, the standardization for this is easily achieved since 67% of Kansas hospitals already use red for allergy alert.

“Patient safety is our first priority”
**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 band 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)
Recommendations for Adoption – June 2008

**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 or clasp, “Restricted Extremity.”

**FAQs**

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

A. At the present time most Kansas hospitals are not using a wristband to denote restricted extremity, but many want to start this practice. Therefore, hospitals will have the option of using a pink wristband to signify limited extremity if they so choose.

**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.
Recommendations for Adoption – June 2008

**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 or clasp, “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.** Similar to the optional use of the color pink for limited extremity, the color green was chosen as an option to signify a patient allergy to latex. This is consistent with what states such as Minnesota, New Jersey, Washington and Colorado have chosen to represent a latex allergy.
Risk Reduction Strategies

<table>
<thead>
<tr>
<th>Color-coded “Alert” Wristbands / Risk Reduction Strategies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quick Reference Card</strong></td>
<td></td>
</tr>
<tr>
<td>1. Use wristbands with the alert message pre-printed</td>
<td></td>
</tr>
<tr>
<td>(such as “DNR”).</td>
<td></td>
</tr>
<tr>
<td>2. Remove any “social cause” colored wristbands</td>
<td></td>
</tr>
<tr>
<td>(such as “Live Strong”).</td>
<td></td>
</tr>
<tr>
<td>3. Remove wristbands that have been applied from another</td>
<td></td>
</tr>
<tr>
<td>facility.</td>
<td></td>
</tr>
</tbody>
</table>

| 4. Initiate banding upon admission, changes in condition, |  |
|    or when information 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 band means.
   - a. This can reinforce the color coding system for new clinicians, help caregivers interpret the meaning of the band 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 band 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 safe guard 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 tool kit.

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

7. Educate staff to verify patient color-coded “alert” wristbands upon assessment, hand-off of care and facility transfer communication.
8. When possible, limit the use of colored wristbands.
   a. Such as, for other categories of care (i.e. latex, 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 there of” 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.
Work Plan — How to Implement

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

<table>
<thead>
<tr>
<th>Area #1</th>
<th>Organizational Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>See Task Chart for specific steps</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Area #2</th>
<th>Supplies Assessment and Purchase</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>See Task Chart for specific steps</td>
</tr>
</tbody>
</table>

**Review**

✓ Assessment of current supply
✓ Wristband procurement

**Action Plan**

Most organizations have a vendor they are using for wristbands in Kansas. It is important to communicate to them that you are adopting the Arizona model for color-coded wristbands (and adding an optional pink and green wristband). 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 that the alert message needs to be printed directly on the band (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.
Suggested Work Plan for Facility Preparation, Staff Education and Patient Education  continued

<table>
<thead>
<tr>
<th>Area #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Specific Documentation</td>
</tr>
<tr>
<td>Review</td>
</tr>
<tr>
<td>✓  Policy adoption ✓  Assessment Revision ✓  Forms revised to meet standards ✓  Consents</td>
</tr>
</tbody>
</table>

**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 band, do you have a document indicating this? Perhaps this needs to be discussed by your Patient Safety Committee. A sample has been provided in this Tool Kit.

Coordinate with: Risk Management Staff and individual Hospital Administrators

<table>
<thead>
<tr>
<th>Area #4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff and Patient Orientation, Education and Training</td>
</tr>
<tr>
<td>Review</td>
</tr>
<tr>
<td>✓  Schedule/training content ✓  Documentation requirement ✓  Posters &amp; FAQs</td>
</tr>
</tbody>
</table>

**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 our first 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:</td>
<td><strong>Committee</strong></td>
</tr>
<tr>
<td>~ Medical Staff Committee</td>
<td>Medical Staff Comm.</td>
</tr>
<tr>
<td>~ Nursing Practice Council</td>
<td>Nursing Practice Council</td>
</tr>
<tr>
<td>~ Quality Improvement Council</td>
<td>Quality Improvement Council</td>
</tr>
<tr>
<td>~ Board of Directors</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>~ Other?</td>
<td>Other</td>
</tr>
</tbody>
</table>

**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.

**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></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>
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<tr>
<td></td>
<td>Other</td>
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<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

**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.
## 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>Dept.</th>
<th>Notes / Comments / Follow-ups</th>
</tr>
</thead>
<tbody>
<tr>
<td>After presentations made and approval obtained to adopt recommendations, contact pertinent dept./staff to move forward. Convey info – see right column</td>
<td>Materials Management</td>
<td>Dept. Info to be Conveyed Follow-ups</td>
</tr>
<tr>
<td>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.)</td>
<td></td>
<td>How long until delivery?</td>
</tr>
<tr>
<td></td>
<td>Staff Education</td>
<td>1. Wristbands will be arriving in about _______ weeks. 2. “Go Live” Date is _______ weeks. 3. OK to start education.</td>
</tr>
<tr>
<td></td>
<td>Risk Management and/or QI Director</td>
<td>1. Wristbands will be arriving in about _______ weeks. 2. “Go Live” date is _______ weeks. 3. Confirm P&amp;P has been approved and prepare to add to P&amp;P manual.</td>
</tr>
<tr>
<td></td>
<td>Other Departments to consider: Medical Staff, Admitting, ED, Peri-Op, Nursing, Lab, Dietary, Laboratory, Radiology, Pharmacy, etc.</td>
<td>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.</td>
</tr>
</tbody>
</table>

“Patient safety is our first priority”
### Task Chart for Facility Preparation

#### Area #1 Organizational Approval & Awareness

**STEP 4** If any other steps required, add them here.

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

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

<table>
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<th>What to Do</th>
<th>Notes / Comments / Follow-ups</th>
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</table>
## 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>
<tbody>
<tr>
<td>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.</td>
<td>Coordinated with Materials Management (MM) person who will do the ordering. MM Name: __________________________________________ Email: __________________________________________ Phone: __________________________________________</td>
</tr>
</tbody>
</table>

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

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

#### 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 our first priority*
### Task Chart for Facility Preparation

#### Area #2 Supplies Assessment and Purchase

<table>
<thead>
<tr>
<th><strong>STEP 4</strong></th>
<th><strong>When:</strong> WEEK TWO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What to Do</strong></td>
<td><strong>Other Notes / Cues</strong></td>
</tr>
<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>Complete info in right column from MM.</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>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>STEP 5</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What to Do</strong></td>
</tr>
<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>
</tr>
</tbody>
</table>

#### STEPS 6 & 7

**If any other steps required, add them here.**

<table>
<thead>
<tr>
<th><strong>What to Do</strong></th>
<th><strong>When to Do It</strong></th>
<th><strong>Other Notes / Cues</strong></th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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“Patient safety is our first priority”
## Task Chart for Facility Preparation

### Area #3 Hospital Specific Documentation

<table>
<thead>
<tr>
<th>STEP 1</th>
<th>When: <strong>week TWO or THREE</strong> enter date this is done: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What to Do</strong></td>
<td><strong>Other Notes and Cues</strong></td>
</tr>
<tr>
<td>Contact CNO 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 CNO 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>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 2</th>
<th>When: <strong>week TWO or THREE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What to Do</strong></td>
<td><strong>Other Notes and Cues</strong></td>
</tr>
<tr>
<td>If your current documentation addresses wristband information, review documents to assure any reference to colors are updated to reflect these changes.</td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 3</th>
<th>When: <strong>week THREE or FOUR</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What to Do</strong></td>
<td><strong>Other Notes and Cues</strong></td>
</tr>
<tr>
<td>If changes are required to the documentation forms, contact Forms Committee and pertinent Clinical Directors and initiate process for changes.</td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 4</th>
<th>When: <strong>week THREE or FOUR</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What to Do</strong></td>
<td><strong>Other Notes and Cues</strong></td>
</tr>
<tr>
<td>Once process is known, and if a form(s) update is required, factor the print time and new form availability into the timeline so the education and implementation processes are in sync with the arrival of new documents.</td>
<td></td>
</tr>
</tbody>
</table>
## 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>
<tbody>
<tr>
<td>The Policy and Procedure for wristband application needs to be reviewed and updated to reflect the new process.</td>
<td>A sample P&amp;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&amp;P and determine what elements you will change. The sample P&amp;P is not prescriptive but rather suggestive.</td>
</tr>
<tr>
<td>Obtain a copy of the current wristband P&amp;P and review content.</td>
<td></td>
</tr>
</tbody>
</table>

#### 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. | 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. |
| Coordinate this with the departments that have “unique” P&Ps so all are changed at the same time. |                                                                                                                                                   |
## Task Chart for Facility Preparation

### Area #3 Hospital Specific Documentation continued

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

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

<table>
<thead>
<tr>
<th>STEP 10</th>
<th>If any other steps required, add them here.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What to Do</td>
<td>Other Notes and Cues</td>
</tr>
</tbody>
</table>
## 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 tool kit. 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 our first priority”
| **STEP 4** When: **THREE to FOUR weeks** | **Other Notes and Cues** |
| What to Do | 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. |
| | 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. |

| **STEP 5** When: **TWO weeks before Train the Trainer Session** | **Other Notes and Cues** |
| What to Do | Make one copy of the Education section of this tool kit 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. |
| | Updates will be occurring to this tool kit as new information is added or great suggestions are made by the users. Be sure to visit the website where the tool kit is posted and check for any updates before you make all of the copies of materials. Our website is: [www.kha-net.org](http://www.kha-net.org). Specific section on the website is [http://www.kha-net.org/CriticalIssues/PatientSafety/default.aspx](http://www.kha-net.org/CriticalIssues/PatientSafety/default.aspx) |

| **STEP 6** When: **THREE weeks before Staff Education Roll-out** | **Other Notes and Cues** |
| What to Do | Send out a reminder email to all Trainers reminding them to make copies of the following hand outs for their staff: ~ Staff education brochure ~ Patient education brochure ~ FAQs ~ Posters announcing the meeting (there are three to choose from) ~ Sign-in sheet ~ Competency check list (if you are using that) |
| | 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, green and pink “props” or candy – like M&Ms, Skittles or other such things. |

| **STEP 7** If any other steps required, add them here. | **Other Notes and Cues** |
| What to Do | |
| | |
Staff and Patient Education Materials

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

“Patient safety is our first priority”
Staff Education Training Tips

Introduction

The following section regarding staff education has been developed knowing that you may choose to do all of this, or part of it. We hope that we have made this section comprehensive without being overly burdensome. Make this plan work for you; use what you want and remember the goal is to communicate the changes with color-coded alert wristbands to your staff.

This section was created with the following design objectives in mind:

1. Staff can be easily guided through the changes with color-coded alert wristbands;
2. The instructors are well equipped to teach about these changes;
3. No new materials have to be created by staff; this should be nearly a “turn key” education event, and
4. Staff can feel confident that all Kansas hospitals are hearing the same message and a similar implementation plan. This is important if staff work at more than one hospital.

Who and how will this be done?

This is a decision that needs to be made within your organization. It can be as simple or formal as you desire. Suggestions include staff meetings, at formal education sessions, annual competencies – what ever works for your organization. It should be done routinely at new employee orientation so the new staff is quickly brought up to speed on this initiative.
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 clerks/secretaries 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 band 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 nurse’s 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.
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 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.

“Patient safety is our first priority”
Follow the story with data results – by sharing with staff how our state uses wristbands makes the information more relevant, and reinforces to them their developing motivation to comply and participate in this. Share this information with staff. It is on one of the panels in the brochure, too.

A survey was conducted in August 2007, of Kansas hospitals to evaluate our risk for such an event. The results showed that **39 different categories of wristbands** were being used in Kansas hospitals including 10 different colors to denote DNR status, 8 colors for Fall Risk status and 5 colors for Allergy.

**Our risk was apparent.**

**Standardize the colors being used for Allergies, Fall Risk, DNR, Restricted Extremity and Latex Allergy in all Kansas hospitals.**

**Our answer is this project.**

The Big Picture – For many individuals, knowing that we are part of a bigger and unique situation fosters pride and again, reinforces the developing motivation to comply. Tell staff how this state is on the forefront of the standardization goal of using the same colors. Share this information with them:

This initiative is being adopted by hospitals statewide. Two states that border Kansas, namely Colorado and Missouri have already adopted this project, as well as twelve states nationwide. Many other states are in the process of standardizing. This makes it safe for us as clinicians and as patients. Once standardization is achieved, it means whether you are traveling on vacation to these states or relocated to work in another state, most hospitals will be using the following colors:

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

“Patient safety is our first priority”
Introduce the Colors – In the tool kit you will find five sample wristbands that show the colors being used and demonstrate the text that is pre-printed on the wristbands. These wristbands are from the vendor The St. John Companies, Inc. If your organization uses a different vendor (check with Materials Management) than you may want to check to see if their bands are available so you can show what you will be using. The colors should be the same since the vendors know the “colors” being used. This is the time to show the bands so there is a visual of the information you are going to share. Review with staff the four bands, the colors and the corresponding meaning. The text box below will walk you through that information.

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

FAQs about the colors selected. This is a companion document to the staff brochure. Research about colors and human association with certain colors contributed to the color selection process in this project. This is important for staff to know so they can feel confident with this process. The FAQ document reviews why the colors were selected and why other colors were not selected. At this time, hand out the FAQ sheet to staff and review with them. Don’t just hand out the FAQs. Make this interactive and ask each person attending to take a question (there are 12) and read the answer to all. This will make the session more interesting. Also, by having staff read and hear the information, they will “re-engage” at this point in the presentation.

You are two-thirds done at this point. Let staff know this so they mentally relax.

“Patient safety is our first priority”
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.

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.

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

4. Initiate banding upon admission, changes in condition, or when information 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.

1. Use wristbands that are pre-printed with text that tells what the band means.
   a. This can reinforce the color coding system for new clinicians, help caregivers interpret the meaning of the band 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 band 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 when 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 safe guard 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 tool kit.

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

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

“Patient safety is our first priority”
Additional points to make:

8. When possible, limit the use of colored wristbands.
   a. Such as, for other categories of care (i.e. latex, 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.
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.
And finally.... Review with staff the points listed below. These are the items that are listed on the competency 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 and Procedure. Be sure your policy covers the below listed areas as they are also a part of the competency. If your policy does not address any of the items on the competency, than 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 Band
- Communication re wristbands during transfers and other reports.
- Patient refusal to comply with policy
- Discharge Instructions for home and/or facility transfer

Training materials are available online in a pdf file. To access them, go to our website at: http://www.kha-net.org/CriticalIssues/PatientSafety/default.aspx

“Patient safety is our first priority”
Staff Education — The Tools

1. **Poster announcing the training meeting dates/times**
   (Document Provided)

   The following posters were created to announce the meetings and the initiative. Post them in the staff lounge, communication boards, employee locker room, staff bath rooms, where ever you feel staff will see it.

   Training materials are available online in a pdf file.
   To access them, go to our website at: [http://www.kha-net.org/CriticalIssues/PatientSafety/default.aspx](http://www.kha-net.org/CriticalIssues/PatientSafety/default.aspx)
20 minutes will tell you what to expect with the new changes

Join us on the following dates for the training session about Color-coded Alert Wristbands.

Day / Date / Time: ________________________________________________________________
Location: ______________________________________________________________________

Day / Date / Time: ________________________________________________________________
Location: ______________________________________________________________________

Day / Date / Time: ________________________________________________________________
Location: ______________________________________________________________________

Questions? Contact: ___________________________ ext: ___________

“Patient safety is our first priority”
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”
Join us on the following dates for the training session about Color-coded Alert Wristband Standardization.

Colors are FUN but patient safety is NOT A GAME

MATCH GAME

“DNR” yellow
ALLERGY purple
FALL RISK pink
RESTRICTED green
EXTREMITY red
LATEX ALLERGY
Staff Education — The Tools continued

2. Staff Sign-In Sheet (Document Provided)

Sample — Completed Staff Sign-In Sheet

- Use this form so there is a record of all staff that attended the training session.

- Make copies so you don’t use the last one.

- If you use the last one, go to http://www.kha-net.org/CriticalIssues/PatientSafety/default.aspx. At the home page, click on the Patient Safety tab. You will see the Color-coded Alert Wristband link – just click on that. Find the file that contains the document you are looking for. Find the file that says “Staff Sign-In Sheet.”

- Keep this sign–in sheet with your staff meeting / training folder. The Joint Commission or other regulatory agencies may ask you for it. This is especially important if you are making this a mandatory participation session.

“Patient safety is our first priority”
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: ___________
Staff Education — The Tools continued

3. **Staff competency check list** *(Document Provided)*

We recognize that some organizations will opt to use this form and some will not. Should you decide to use a competency check list in your process, we hope this form will provide the documentation you need. This form also serves as a great check list for the trainer so all of the important elements in the training are remembered and taught.

If you do not use this as a staff form, consider using it as your form to help you remember every element you should be reviewing with staff about the changes with the color-coded alert wristbands.

Training materials are available online in a pdf file.
To access them, go to our website at: [http://www.kha-net.org/CriticalIssues/PatientSafety/default.aspx](http://www.kha-net.org/CriticalIssues/PatientSafety/default.aspx)
## Staff Competency Checklist

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

<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 four colors mean?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Who can apply the wristband to the patient?</td>
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<td>Discharge Instructions for home and/or facility transfer</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.

### Methods to Use:

- A. Demonstration
- B. Direct Observation/Checklist
- C. Video / PowerPoint Review
- D. Skills Lab
- E. Self Study/Test
- F. Data Management
- G. Other

**Supervisor’s initials signify competency was met.**

---

**Employee Name**

**Job Title**

**Employee Signature**

**Initials**

**Date**

**Signature**

**Initials**

---

**Employee Signature**

**Date**
Staff Education — The Tools continued

4. **Tri-fold brochure called “Staff Education Regarding: Color-coded “alert” Wristbands”**
   (Document provided)

   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.

5. **Tri-fold brochure called “Patient Safety: Understanding what your color-coded “alert” wristbands mean”**
   (Document provided in English and Spanish)

   This brochure was created to hand out to patients and family members so they understand what the wristband colors mean and can confirm the information. Patients should have this information whether they need a color-coded wristband, or not, because new information may surface due to this education. For example, perhaps a patient has an allergy to a certain food but was thinking only about medications when first asked about allergies. During a family visit, a loved one could read this information brochure and bring up the food allergy. This can now be corrected and the patient is not at risk due to an oversight.

Training materials are available online in a pdf file. To access them, go to our website at: [http://www.kha-net.org/CriticalIssues/PatientSafety/default.aspx](http://www.kha-net.org/CriticalIssues/PatientSafety/default.aspx)
How this all got started...

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.

What about Kansas?

Kansas has a goal of providing safe and high quality care. We accomplish this in several ways, one of which includes using the same colors for “alert” wristbands. Most hospitals are adopting the same colors so regardless of which hospital you work at today or tomorrow, the color coded alert wristbands should be the same color for Allergy, the same color for Fall Risk, the same color for Do Not Resuscitate, the same color for Restricted Extremity, and the same color for Latex Allergy.

The Big Picture

This initiative is being adopted by hospitals statewide. Two states that border Kansas, namely Colorado and Missouri, have already adopted this project, as well as twelve states nationwide. Many other states are in the process of standardizing. This makes it safe for us as clinicians and as patients. Once standardization is achieved, it means whether you are traveling on vacation to these states or relocated to work in another state, most hospitals will be using the following colors:

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

Staff Education Regarding:

Color-coded “alert” wristbands

Information intended for all staff, clinical and non-clinical.
**Color-coded Alert Wristbands – A Statewide Patient Safety Initiative**

A survey was conducted in August 2007, of Kansas hospitals to evaluate our risk for such an event. The results showed that 39 different categories of wristbands were being used in Kansas hospitals including 10 different colors to denote DNR status, 8 colors for Fall Risk status and 5 colors for Allergy.

Our risk was apparent.

Standardize the colors being used for Allergies, Fall Risk, DNR, Restricted Extremity and Latex Allergy in all Kansas hospitals.

Our answer is this project.

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, there is a better chance patients and families will understand what we are saying.

**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.

---

**Other Risk Reduction Strategies Staff Should Know**

**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 received during hospital stay.
5. Educate patients and family members regarding the wristbands.
6. Coordinate chart/whiteboard/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.
Our hospital is proud to be a supporter of this collaborative work, making healthcare safer and better for patients and their families.

Kansas healthcare providers are working together to make patients safe. We accomplish this goal by working together on statewide projects in an endeavor to use the same methods or processes, like color-coded wristbands.
Statewide Patient Safety Initiatives

Patient safety is a top priority for Kansas. 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 Alabama, Arizona, California, Colorado, Florida, Nevada, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, Texas, Utah, Washington, 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.

- **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.

- **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.

- **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.
Nuestro hospital está orgulloso de apoyar este trabajo de colaboración para permitir que haya mejor atención médica y más segura para los pacientes y sus familias.

Los proveedores de atención médica de Kansas están trabajando conjuntamente para lograr que Kansas sea el estado más seguro en la nación. Alcanzaremos esta meta trabajando juntos en proyectos a nivel estatal en un esfuerzo por usar los mismos métodos o procesos, como los brazaletes de código por color.

Seguridad de pacientes: entender lo que significa el código por color en el brazalete de “alerta”
**Iniciativas Estatales para la Seguridad de Pacientes**

Kansas tiene la meta de ser el estado más seguro de la nación. Alcanzaremos esta meta de diversas maneras, una de las cuales incluye el uso de los mismos colores para los brazaletes de “alerta.” Esta iniciativa no es únicamente a nivel estatal, sino también en todos los estados en la región suroeste de la nación (Alabama, Arizona, California, Colorado, Florida, Nevada, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, Texas, Utah, Washington, y West Virginia).

**¿Qué es un brazalete de “alerta” de código por color? Pacientes y Familiares**

Los brazaletes de alerta se usan en los hospitales para comunicar rápidamente un cierto estado de atención médica o una “alerta” que el paciente pueda tener. Esto se lleva a cabo para que cada miembro del personal pueda proporcionar la mejor atención posible, aún y cuando no conozca al paciente. Los diferentes colores tienen significados determinados. Las palabras para las alertas también están escritas en el brazalete para reducir la posibilidad de confundir los mensajes de alerta.

**¿Qué significan los diferentes colores?**

Hay cinco diferentes códigos de color para los brazaletes de “alerta” a los que nos vamos a referir debido a que son los más usados comúnmente.

- **ROJO significa ALERTA DE ALERGIA**
  - ALLERGY

  Si un paciente tiene una alergia a algo – alimento, medicina, polvo, pasto, pelo de animal, CUALQUIER COSA – por favor infórmenoslo. Tal vez no le parezca de gran importancia a usted pero podría ser sumamente importante para la atención que reciban.

- **MORADO significa NO RESUCITAR**
  - “DNR”, por sus siglas en inglés

  Algunos pacientes han expresado un deseo de no ser resucitados en caso de ser requerido para conservarlos con vida y queremos respetar ese deseo.

- **AMARILLO significa RIESGO DE CAÍDA**
  - FALL RISK

  En todo momento queremos prevenir las caídas. Las enfermeras revisan a los pacientes todo el tiempo para determinar si necesitan atención adicional para prevenir una caída. Algunas veces, una persona podría debilitarse durante el curso de su enfermedad o debido a que acaba de tener una cirugía. Cuando un paciente tiene un brazalete de alerta con este código de color, la enfermera está diciendo que esta persona necesita recibir ayuda al caminar o podría sufrir una caída.

- **ROSADO significa Extremidad Restringida**
  - RESTRICTED EXTREMITY

  Cuando un paciente tiene un brazalete con este código de color, el proveedor de cuidado de la salud está indicando que la extremidad de este paciente debe ser manejada con extrema cuidado. Se alerta a otros proveedores de cuidado de la salud que deben consultar con la enfermera antes de realizar cualquier prueba o procedimiento.

- **VERDE significa Alergia al Látex**
  - LATEX ALLERGY

  Cuando un paciente tiene un brazalete con este código de color, indica que tiene reacción alérgica al látex. Este brazalete verde alertará a los doctores, enfermeras y otros profesionales del cuidado de la salud sobre su alergia.

**Involucrando a los pacientes y a los familiares**

Es importante que el paciente y su familia conozcan estos colores y sus significados porque usted en nuestra mejor fuente de información. Además, si usted cuenta con una Directiva por adelantado, digánselo. Una Directiva por adelantado le informa a su doctor el tipo de atención que usted desearía si usted se ve imposibilitado de tomar decisiones médicas. Queremos respetar y hacer honor a los deseos de los pacientes y ello se puede lograr mejor cuando tenemos toda la información.
Staff Education — The Tools continued

6. FAQ handout for staff (Document Provided)

This hand out was created to offer further clarification regarding the changes being made. You can use this as a hand out or to post in staff areas as well.

Training materials are available online in a pdf file. To access them, go to our website at: http://www.kha-net.org/CriticalIssues/PatientSafety/default.aspx

“Patient safety is our first priority”
FAQs about Color-coded Alert Wristbands

Q#1. In the past, we never used wristbands. Why should we consider it now?
A. 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 core staff employed by the hospital. Now, an increasing number of healthcare providers are not hospital based staff, so it is imperative that current processes take this into consideration.

Q#2. We don’t use wristbands for DNRs at this hospital. Why should we consider adopting this?
A. Wristbands are used in most KS hospitals to communicate an alert. Registry staff, travelers, non-clinical staff, etc. may be unaware of where to look in the medical record if they are new to your hospital. By having a wristband on, a quick warning is communicated so anyone could know about this alert. Additionally, it is also a means to communicate to the family that we are clear about their end of life wishes. By not having a band on, errors of omission could potentially be created.

Q#3. Why not use Blue for DNR?
A. At first we considered blue as an option. However, a survey of KS hospitals indicated some hospitals call a code by announcing “Code Blue.” 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.

Q#4. So, if we adopt the purple DNR wristband then do we still need to look in the chart?
A. Yes. Code status can change throughout a hospitalization. It is important to know the current status so the patient’s and families wishes can be honored. Always validate that there is an order by a physician for the DNR designation.

Q#5. Why did you select red for Allergies?
A. Red was selected due to the results of an August 2007 survey conducted with Kansas hospitals that indicated two out of three hospitals already use the color red. It just made sense to continue with an established color.

Q#6. Besides that, are there any other reasons for using red for Allergies?
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 band they are prompted to “STOP!” and double check if the patient is allergic to the medication, food, or treatment they are about to receive.

Q#7. Do we write the allergies on the wristband too?
A. No - it is our recommendation that allergies be written in the medical record according to your hospital’s policy and procedure. We suggest allergies not be written on the wristband for several reasons:

1. Legibility make hinder the correct interpretation of the allergy listed;
2. By writing allergies on the wristband someone may assume the list is comprehensive. However, space is limited on a wristband. The risk is that some allergies would be inadvertently omitted – leading to confusion or missing an allergy;
3. Throughout a hospitalization, allergies may be discovered by other caregivers, such as dieticians, radiologists, pharmacists, etc. This information is typically added to the medical record and not always a wristband. By having one source of information to refer to, such as the medical record, staff of all disciplines will know where to add newly discovered allergies.
FAQs about Color-coded Alert Wristbands

Q#8. Why did you select yellow for Fall Risk?
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#9. Why even use an alert band 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

Q#10. Who decided on these colors?
A. The Kansas project is part of a national initiative, which is modeled after the original work by Arizona. The consensus of Kansas hospitals was to add an optional green wristband to indicate latex allergy and an optional pink wristband to indicate restricted extremity. A total of five colors for patient wristbands will be standardized throughout the state for those hospitals using color-coded wristbands.

For questions or comments regarding this project, please direct to:
Deborah F. Stern, RN, Esq.
Vice President Clinical Services/Legal Counsel
Kansas Hospital Association
215 SE 8th Avenue
Topeka, KS 66603
Phone: (785) 233-7436
Fax: (785) 233-6955
Email: dstern@kha-net.org
Staff Education — The Tools continued

7. PowerPoint (with speaker notes)

This presentation was created to provide alternate teaching methods for the trainer. It can be used in large and small groups. Please check our website periodically as we will update the presentation as needed. To do that, go to http://www.kha-net.org/CriticalIssues/PatientSafety/default.aspx. The CD in your tool kit also contains this PowerPoint presentation.
Executive Summary

Background:

• In Pennsylvania there was confusion regarding wristband color that resulted in a patient being labeled DNR erroneously
• In August 2007, the Kansas Hospital Association collected baseline data to assess if wristband color variation existed in Kansas hospitals
• In 2008, the KHA Quality and Patient Safety Technical Advisory Group and the KHA Council on Health Delivery reviewed the results

What about staff impact?

• New staff – Kansas hospitals reported an RN vacancy rate of 8.8% (2007)
• RN turnover at 12.0% (2007)
• Use of agency and travelers

What did we conclude?

• Potential for confusion exists
• Opportunity to reduce potential for harm and improve patient safety

What did we do?

• KHA reviewed the growing national trend to adopt standardized wristband color program
• KHA surveyed its member hospitals in August 2007 and found that 39 categories and over 18 colors were being used for patient wristbands
• The decision was made to use 3 standard colors with 2 optional colors
• In March 2008, the KHA Board of Directors approved a recommendation for Kansas Hospitals to use a 3-5 color patient wristband standardization program
• Hospitals should have program in place by January 1, 2009
Color-coded Wristband Standardization in Kansas

Color-coded Wristband Standardization Tool Kit Created for Kansas Hospitals

The Tool Kit contents include:

1. The colors for the alert designation
2. The logic for the colors selected
3. A work plan for implementation
4. Staff education including competencies

Color-coded Wristband Standardization Tool Kit Created for Kansas Hospitals

The Tool Kit contents include (cont.):

5. FAQs for general distribution
6. Sample policy and procedure
7. Vendor information for easy adoption
8. Patient education brochure

Color-coded Wristband Standardization in Kansas

Executive Summary

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 for Adoption

Do Not Resuscitate

Recommendation: DNR - Purple

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

Do Not Resuscitate

Recommendation - PURPLE for Do Not Resuscitate

1. Why not blue?
   – Should not be the same color that is used for calling a code
   – Registry, turnover, travelers, etc
2. Why not green?
   – “Go ahead” confusion
3. If we adopt purple, do we still need to look in the chart?
   – Yes!
   – Code designation can and does change during a patients stay

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**Allergy**

**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 or clasp, “ALLERGY.”

Quick Adoption

By adopting red for allergy alert, the standardization for this is easily achieved since 67% of KS hospitals already use red for allergy alert.

**Fall Risk**

**Recommendation: Fall - Yellow**

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

**Restricted Extremity**

**Recommendation - Pink for Restricted Extremity**

- It is recommended that hospitals adopt the color of Pink for the Restricted Extremity Alert designation with the words embossed / written on the wristband or clasp, “Restricted Extremity.”
**Recommendation - Green for Latex Allergy**

It is recommended that hospitals adopt the color of GREEN for the latex allergy alert designation with the words embossed/written on the wristband or clasp, “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.

**A Suggested Work Plan for Facility Preparation, Staff Education, and Patient Education that includes:**

1. Organizational Approval
2. Supplies Assessment and Purchase
3. Hospital Specific Documentation
4. Staff and Patient Education Materials and Training

Following the Work Plan is a Task Chart for each plan that provides cues for methodical and successful implementation.

**Sample Task Chart**
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Color-coded Wristband
Standardization in Kansas

Staff Education Tools

1. Poster announcing the training meeting dates/times
2. Staff Sign-In Sheet
3. Staff competency check list
4. Tri-fold Staff education brochure about this initiative
5. FAQs hand out for staff
6. Tri-fold Patient education brochure about color-coded wristbands
• PowerPoint presentation

Tools for Staff Education:

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

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

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 messages – which helps with retention of the information.
5. Patient Education brochure also available for staff to hand out.
What is a Color-coded “Alert” Wristband?
Color-coded alert wristbands are used in hospitals to quickly communicate a certain health care 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 the most commonly ones used.

- continued on next slide -

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.

~ continued on next slide ~

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

GREEN means Latex Allergy
The nurse is indicating that the patient has or may have an allergy to latex and latex products which could cause anaphylaxis, a potentially life-threatening condition.

PINK means Restricted Extremity
The nurse 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.

~ continued on next slide ~

Excerpt from Refusal Form
The above named patient refuses to: (check what applies)

Ƒ 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 risks 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.

Ƒ 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

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“Patient safety is our first priority”
Policy and Procedure

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

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Policy and Procedure Template

Policy name: Color-coded Wristbands

1. **Purpose**

   To have 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 wrist bands 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. To 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.

KHA 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
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Vendor Information

Most providers belong to a Group Purchasing Organizations (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 our first priority”
To access the Tool Kit

The Kansas Hospital Association is pleased to share the contents of this tool kit with hospitals in Kansas based upon permission from the Arizona Hospital and Healthcare Association and in particular Barb Averyt, Program Director, Safe and Sound. On behalf of KHA, we want to thank Barb and her workgroup for their passion, excellent tools and willingness to share to make this quality project possible in Kansas.

You may access the online information at


To discuss this project or obtain information, please contact:
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Acknowledgements

The Kansas Hospital Association wishes to acknowledge the assistance of the KHA Quality and Patient Safety Technical Advisory Group and the KHA Council on Health Delivery for their support of this project.
Sponsorship

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

Karen Joseph
Senior Product Manager – Wristbands / Patient Safety
The St. John Companies, Inc.
25167 Anza Drive
Valencia, CA 91355
Phone: (800) 435-4242 x 448
Fax: (661) 257-2587
Email: k joseph@stjohninc.com
Web: www.stjohninc.com
www.patientIDexpert.com
“Patient safety is our first 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 alerts 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 alerts.

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 Kansas. The following states have already implemented their color-coding initiatives and have chosen St. John as their patient ID partner: Alabama, Arkansas, Arizona, California, Colorado, Florida, Kansas, Minnesota, Missouri, Nevada, New Mexico, Oregon, Texas, Utah and Wyoming.

**Consolidate your admit and alert wristbands “In-A-Snap”!**

For a complete selection of patient identification wristbands, including barcodable thermal and laser products, visit us online at [www.patientIDexpert.com](http://www.patientIDexpert.com)
Comply with your state color-code standardization initiative “In-A-Snap™”

St. John has teamed up with many hospital associations to help them achieve their color-coded standardization initiatives. By using St. John’s proprietary In-A-Snap™ alert clasps you also comply with the color-code standardization initiatives currently being adopted in your state and in many states across the USA.

In-A-Snaps are being used in hundreds of hospitals because they:

- Comfortably consolidate your admit and alert wristbands into one
- Eliminate the risk of alert wristbands becoming obscured by other wristbands or patient’s gown
- Meet state standardization requirements by combining BOTH colors and words
- Help to eliminate alert wristband mistakes and confusion improving patient safety

Tamper Evident Alert Labels

Consolidate multiple alerts on your laser wristband

- Consolidate multiple alerts on one wristband increasing patient comfort and safety
- Tamper evident destruct marks increase security
- Use of standardized colors with words meet hospital association guidelines for color-code standardization
- Available in roll or sheet format
- Label size 11/16" x 1/4"
- Cost effective
- Synthetic material is durable and long lasting

For a complete selection of patient identification wristbands, including barcodable thermal and laser products, visit us online at www.patientIDexpert.com

ONLINE: www.stjohninc.com • www.patientIDexpert.com • PHONE: 800.435.4242
FAX: 800.321.4409 • EDI: via GHX • ADDRESS: 25167 Anza Drive, Valencia, California 91355
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.

For a complete selection of patient identification wristbands, visit us online at www.patientIDexpert.com
Conf-ID-ent™ ScanRite™ Thermal Wristbands

The ScanRite™ adhesive and clasp closure wristbands offer low cost and the ease of printing with a thermal printer. A barcode printed by a thermal printer uses heat transfer to create a crisp barcode image resulting in reliable first time read rates. Barcode printers are compact in size with their small footprint. Supports text, linear, 2D and Aztec barcodes.

A thermal wristband is:
- Perfect for barcoding
- Durable – Alcohol, soap and water resistant
- Tamper proof or tamper evident
- Cost effective
- Easy to use
- In-A-Snap™ alert clasps can be used with clasp closure wristbands

Conf-ID-ent™ Laser Wristbands and Chart Labels

St. John offers the largest variety of laser wristband and chart labels that work with most laser printers. Laser wristbands and chart labels support text, linear, 2D and Aztec barcodes.

- Clear fold over laminating shield protects the integrity of the patient’s information
- Water resistant materials protects patient data
- Optional tamper evident adhesive closure
- Convenient pre-drilled filing holes 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.

- Easy-to-scan flat surface supports linear, 2D and Aztec barcodes
- Reliable first time read rates
- Laser printable patient information can be generated with most laser printers to improve patient safety
- Choice of styles: Mother/Baby imprinted with yellow ducks or plain white bands, adult adhesive closure or our new exclusive tamper proof clasp closure
- Mother/Baby available with sequential serialization

For a complete selection of patient identification wristbands, visit us online at www.patientIDexpert.com

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