



Holy Spirit Health System
on behalf of the **Color of Safety Task Force**
Camp Hill, Pennsylvania

Franchesca J. Charney, RN
Director Risk Management/Patient Safety
Holy Spirit Health System
Camp Hill PA 17011

Banding Together for Patient Safety

The Color of Safety represents a consortium of hospitals from Pennsylvania that decided the focus on patient safety superseded the interests of the individual hospitals. The hospitals successfully collaborated and agreed to reduce the risks associated with the use of colored wristbands by standardizing the meaning of the colors, limiting the number and colors of the bands to avoid confusion, embossing the bands to reinforce the message conveyed, and removing or covering colored charity wristbands so they are not misinterpreted as a hospital alert band.

In December 2005, the Pennsylvania Patient Safety Authority (PSA) (<http://www.psa.state.pa.us>) released a patient safety advisory making hospitals aware of the inherent risks associated with the use of patient colored wristbands, commonly used by hospital staff to convey significant clinical information. The advisory was incited by a near miss report in which clinicians nearly failed to resuscitate a patient who was incorrectly designated as Do Not Resuscitate (DNR) because a nurse had unknowingly placed a yellow wristband on the patient. In that hospital, the color yellow signified DNR. That nurse also worked at another hospital in which the color yellow signified restricted extremity not to be used for phlebotomy or IV access.

After collecting statewide data, the PSA released alarming statistics on the inconsistencies associated with the colored wristband alerts being used throughout our Commonwealth. Recognizing how these inconsistencies have led to near miss patient errors, and with no guidelines in place, the Pennsylvania Safety Authority had planned to facilitate a work group of representatives from several states and national healthcare organizations to address standardization of color-coded wristbands. However, by April 2006 a call to action was already afoot by a small group of hospitals in Lackawanna County who decided to be proactive and start a grassroots effort dedicated to facing this dilemma. The goal of the committee was to develop strategies that would be accepted as standard of practice and spread statewide or nationwide. Initially the core group of hospitals represented the Scranton vicinity of the Commonwealth. Participation which had begun in Lackawanna!

A County quickly expanded into more: Monroe, Wyoming, Wayne, Luzerne and Cumberland. In addition to the hospital commitment, the group included a community representative for viewpoint on how the changes and the educational tools will be perceived, as well as an individual with color-blindness to associate the magnitude of the potential risk.

Correctly identifying patients is one of The Joint Commission National Patient Safety Goals. In a recent Joint Commission International Center for Patient Safety article, research showed incorrect patient identification was involved in 13% of surgical errors and 67% of transfusion errors. Color coded bands are used in many facilities to identify different patient needs.

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As noted by Charlene D. Hill, The Joint Commission’s media relations manager, the confusion over these bands can be compared to potential hazards caused by look-alike and sound-alike drugs. Staff would need to be acutely aware of the dangers and the potential for confusion and take steps, if necessary, to avoid any confusion. As reported by The Joint Commission, errors have been shown to decline when the proper monitoring of ID bands is established.

From the onset, the leadership of each individual hospital cooperated and remained focused on improving safety. Each participating hospital had to be amendable and modify a procedure, adopt a new procedure, or retire an existing procedure. As a result, all participating hospitals agreed to the following:

- a. Adopting the risk reduction strategies listed in the Patient Safety Advisory and limiting the spectrum of color-coded wristbands to five primary, standardized colors.
- b. Embossing the bands with intended meaning.
- c. Selecting colors that correspond to ease of recognition to the adult learner as follows:

<u>Band Color</u>	<u>Communicates</u>	<u>Implies</u>
Red	Allergy	Stop
Yellow	Fall Risk	Use caution
Green	Latex Allergy	Environmental
Purple*	DNR	Cyanosis
Pink	Restricted Extremity	Komen Foundation

*Recent change (late 2007) from blue to purple to ensure National Patient Safety of Color-Coded Wristbands

- d. Restricting patient use of charity bands on hospital grounds.
- e. Developing documentation tools that can be used as a template and adopted at all facilities, including an administrative policy, patient refusal form, documentation form and competency checklist for staff members.
- f. Creating educational posters and pamphlets for community, patients and staff this could be modified by applying the individual facility logos.
- g. Engaging and educating the public by drafting and distributing letters to community agencies regarding the wristband initiative.
- h. Developing power point presentations for community education.
- i. Establishing a timeline for implementation.

Via letters and publications, local community health care providers such as but not limited to ambulance teams, nursing homes, personal care homes, and outpatient services were notified of the color banding modifications and interpretations. Agencies such as oncology centers, dialysis centers and vascular labs were particularly interested in the new pink restricted extremity band.

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The committee developed an in-depth tool-kit that could be adopted or adapted by any hospital. As word spread of the project outside the local community a wave of national interest was launched. A Standardization and Implementation Manual was developed included six chapters to walk any healthcare facility easily through the necessary steps to success as well as an implementation plan. The ease of replication is in the ability to download the entire format and modify the forms with individual headings and logos. The information was submitted to the Pennsylvania Patient Safety Authority. The Color of Safety Task Force was invited to present their work to the Pennsylvania Safety Authority Board in August 2006. Shortly thereafter, the Authority released a Supplementary Patient Safety Advisory which detailed the work of the group and announced the availability of the tool kit on their website at www.psa.state.psa.us. (Listed under Advisories).

The color banding process we developed is now fully implemented throughout our area. This project has resulted in strategies to reduce the risk to patients by making improvements in three major areas associated with sentinel events; communication, patient identification, and hand-offs in care. The project has facilitated change on numerous levels. The project has shown local hospitals should not be discouraged or intimidated by a why try or where do we start ideation. Our small, grassroots effort illustrates what you can achieve when you focus on patient safety. Our task force members came to the table with the understanding they would leave their individual facility egos at the door. The committee was to concentrate on doing what was right for the patient.

Surveys were conducted at the various participating hospitals. Clinicians affected by the policy changes were asked to quantify the impact they feel the program has had on patient safety in their respective hospitals. Some comments are as follows:

- Used allergy bands, but now am more cautious.
- Used red band, but these make you look.
- Improved communication, especially to ancillary staff.
- Documentation better on Kardex.
- Staff able to better visualize fall risks.
- Staff more aware of latex allergies now.
- Improves communication and awareness.
- Improved communication between people.
- Find the bands useful, especially when there is a high turnover and volume of patients.
- Various Lab and vascular lab staff from different facilities really like them.
- Improves communication for nursing and ancillary- better than signs over the bed.
- Improved communication for all health care providers as well as assurance to patient.
- Thank you for helping to preserve the vascular systems in the arms of our dialysis patients.

Henceforth, PA-PSRS (Pennsylvania Patient Safety Reporting System) will be supportive in providing statistical data for individual hospitals to review their own incidents and trending variables as they pertain to falls, allergies, wrong arm draws, etc. both pre and post revisions.

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The color of safety initiative has not ended with the consortium of Pennsylvania hospitals initiative. Members have worked collaboratively with the Hospital and Healthsystem Association of Pennsylvania (HAP), State Legislators, Pennsylvania's Patient Safety Authority and some of our members are continuing to move patient safety forward with involvement in a national collaboration for the color of safety.

The project embodies the key principles of a culture of safety, teamwork, openness that is patient-centered and process-driven. The outcome has been so gratifying. The team takes pride in knowing that mutual understanding and cooperation has led to improved quality and safety for the treatment and services to the patients under our care. When we began this initiative none of us had the foresight to realize the impact we would have not only within the Commonwealth but also in the nation.

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