Frequently Asked Questions

Improving patient safety, including reducing risks of injury or harm, is a strategic focus of the Michigan Health & Hospital Association (MHA) through its Keystone Center for Patient Safety & Quality. As the MHA seeks to further hospitals' role in achieving the best in patient care through its agenda of accountability, the association has established the first patient safety organization in Michigan. **As its first endeavor, the MHA Patient Safety Organization (PSO) is engaging hospitals in an effort to improve communication and reduce the risk of patient harm through the standardization of color-coded patient alert wristbands.**

Similar initiatives are under way in more than 25 states in an effort to improve patient safety. **This endeavor is *not* meant to encourage those hospitals that presently do not use color-coded patient alert wristbands to adopt the practice.** Rather, the goal is to gain a 100 percent standardization rate among those Michigan hospitals that currently use color-coded patient alert wristbands, ensuring the consistency of three alerts: allergy (red), fall risk (yellow), and do-not-resuscitate (purple).

Questions & Answers

Q: **The hospital has never used color-coded patient alert wristbands. Should we start?**

A: No. The MHA does not encourage hospitals to start using color-coded patient alert wristbands if they do not already use them. The standardization initiative is directed only to those hospitals/health systems that currently use color-coded patient alert wristbands in order to reduce preventable medical errors caused by lack of consistency in alert messages provided to caregivers.

Q: **Why is the MHA leading an initiative to standardize color-coded patient alert wristbands?**

A: The purpose of the initiative is to consistently and effectively communicate an alert to a health care provider if the patient has an allergy, is a fall risk, and/or carries a do-not-resuscitate (DNR) order. With a standardized method of communicating these risks, the potential for confusion when patients, physicians and nurses travel between different hospitals is greatly reduced.

Q: **How long will it take to standardize color-coded patient alert wristbands?**

A: The process is unique for each hospital and can take up to one year. However, in light of Michigan hospitals' historic success in initiating and participating in voluntary patient safety improvement efforts, facilities are being asked to complete this standardization by June 1, 2009.

Q: What colors were chosen for standardization?

A: As of October 2008, more than 25 states have standardized color-coded patient alert wristbands. Consistent with these states and the American Hospital Association, the MHA Patient Safety Organization (PSO) is implementing a color-coded patient alert wristband standardization initiative focused on the three most commonly used patient alert wristband colors: red to indicate allergy, yellow to indicate fall risk, and purple to indicate do-not-resuscitate (DNR).

Q: What is the first step in pursuing standardization?

A: MHA members will be provided learning opportunities and educational tools for conducting this standardization. Member education forums will be hosted in three locations throughout Michigan in late January 2009. At these events, comprehensive color-coded patient alert wristband standardization toolkits will be provided to members at no charge. These toolkits contain numerous sample communications and schedules that inform hospitals about how best to carry out the standardization. This toolkit will be available online and the MHA staff will be available throughout the process to answer questions.

Q: Do color-coded patient alert wristbands infringe on patient privacy and/or violate the Health Insurance Portability and Accountability Act (HIPAA)?

A: The use of color-coded patient alert wristbands does not violate HIPAA. Incidental release of patient information is allowed when necessary for hospital operations. The use of the color-coded patient alert wristbands falls under this allowed limited release of patient information.

Q: Why was purple selected for do-not-resuscitate (DNR)?

A: As other states considered the adoption of the standardized colors, there was a concern that using the color blue may cause confusion when responding to a code. Based on a survey by Michigan hospitals, many hospitals call a “Code Blue” for cardiac arrest. Having a blue DNR wristband to indicate “no code” could easily cause confusion. To avoid creating any second guessing about whether to call a code in this critical moment, blue was not used.

Furthermore, the color green was avoided due to color blindness concerns. Also, the color green often has a “go ahead” connotation, such as with traffic lights. The possibility of sending “mixed messages” in a critical moment must be avoided.

Due to these reasons and to achieve consistency with the majority of states standardizing patient alert wristbands, Michigan selected purple for DNR alert designation.

Q: If the hospital adopts the purple do-not-resuscitate (DNR) wristband, do staff members still need to look in the chart?

A: Yes. Some hospitals do not use wristbands to alert clinicians of an advance directive because they want the clinicians to review the medical record for the patient's most current code designation. A medical record should *always* be reviewed for the patient's most current code designation. Code status can change throughout a hospitalization, and it is important to know the current status, so the patients' and/or families' wishes can be honored.

Q: Why was red selected for allergies?

A: Research of other industries indicates that red has an association that implies extreme concern. The American National Standards Institute (ANSI) has designated certain colors as signifying very specific warnings. ANSI uses red to communicate "stop!" or "danger!" It is believed that this message would also translate when communicating an allergy status. When a caregiver sees a red allergy alert wristband, they would likely be prompted to "stop" and double-check if the patient is allergic to medications, food or the treatment about to be delivered.

Q: Should the patient's allergies be written on the allergy wristband?

A: No. It is advised that allergies be written in the medical record according to the hospital's policy and procedure. Allergies should not be written on the wristband for several reasons:

- Legibility may hinder the correct interpretation of the allergy listed.
- It could be assumed that the list of allergies written on the alert wristband is all-inclusive. However, space is limited on a wristband and some patients may have several allergies. The risk of writing on the wristband is that some allergies would be inadvertently omitted due to lack of space, which can lead to confusion or an assumption that the list is comprehensive.
- 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 on a wristband. By having one source of information to reference, such as the medical record, staff members in all disciplines know where to add and review newly discovered allergies.

Q: Why was yellow selected for fall risk?

A: Research indicates that yellow implies "caution," such as the last color warning before a stop at a traffic light. In addition, the American National Standards Institute uses yellow to communicate "tripping or falling hazards." The color yellow would alert caregivers to use caution with a patient who has a history of falls, dizziness, and difficulty with balance, fatigue or dementia.

Q: Why use an alert band for fall risk?

A: When a patient is wearing a fall risk alert wristband, it notifies **all** hospital staff that the patient needs to be assisted when walking or getting up from a sedentary position.

According to the Centers for Disease Control and Prevention (CDC), falls are of great concern for the aging American population. According to the CDC:

- More than one-third of adults age 65 or older fall each year.
- Older adults are hospitalized for fall-related injuries five times more often than for injuries resulting from other causes.
- Of those adults who fall, 20 to 30 percent suffer moderate to severe injuries that reduce mobility and independence and increase the risk of premature death.
- The total cost of all fall injuries for people age 65 or older in 1994 was more than $27 billion.
- By 2020, the total cost of fall injuries is expected to reach more than $44 billion. Hospital admissions for hip fractures among people over age 65 have increased steadily from 230,000 admissions in 1988 to 338,000 admissions in 1999.
- The annual number of hip fractures is expected to exceed 500,000 by the year 2040. As the aging population enters the acute-care environment, the risk that is present must be considered, and everything possible should be done to communicate that risk to staff. For more information about falls and related statistics, visit www.cdc.gov/ncipc/factsheets/fallcost.htm.

Q: Who chose these colors?

A: The Michigan standardization initiative is modeled after the original work done by the Pennsylvania Color of Safety Task Force, the Arizona Hospital and Healthcare Association and the experiences of other states that have adopted standardized colors for patient alert wristbands. The American Hospital Association has also adopted these wristband colors and patient alert meanings.

MHA Staff Contacts

Members with questions regarding the various activities related to wristband standardization should contact one of the following MHA staff members:

- MHA PSO: Brian Peters, bpeters@mha.org, (517) 886-8223
- Color-coded Patient Alert Wristband Standardization: Sam Watson, swatson@mha.org, (517) 886-8362 or Morgan Martin, mmartin@mha.org, (517) 886-8372
- Media: Lori Latham, llatham@mha.org, (517) 703-8605