Improving Patient Alert Mechanisms: An Academic-Practice Partnership Project

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Summary: In December 2005, the Pennsylvania Patient Safety Reporting System (PA-PSRS) issued a statement outlining an incident of an incorrectly placed colored wristband, resulting in lack of resuscitation and subsequent death of a patient. Following this incident, a national push for the standardization of colors and meaning of alert wristbands from the organization was established. Recommendations included utilization of specific colors for specific meanings, application of pre-printed descriptive text, and incorporation of correct patient verification of wristbands during change-of-shift report. Discussion on the breakdown of clinical research product development, unit implementation, and policy revision to include red “allergy,” yellow “fall risk,” purple “no LSMT,” white “partial LSMT,” and pink “limb alert” wristbands were presented specific to an academic health system utilizing an academic-practice partnership model. Emphasis on in-depth staff educational methods through in-services and printed handouts and possible financial benefits were explored.

Nursing Implications:

- Following PA-PSRS guidelines, nurses should place appropriate wristbands on admission including yellow for fall risk, purple for DNR status, red for allergies, green for latex allergies, and pink for restricted extremities.
- Nurses should verify correct placement of wristbands and clinical risks during bedside shift report.
- Wristbands should be stored in plain site on the unit to encourage use.
- Strategies to improve clinical practice should be evidence-based. Front-line staff are encouraged to join the facility’s shared governance or evidence-based practice council to truly impact patient care at the bedside.

Key Takeaways:

- Facilities should ensure current policies and procedures match PA-PSRS recommendations for color-coded wristbands to prevent patient harm and to improve clinical safety.
- Costs of implementation are far less than possible complications of incorrect placement of wristbands (fall-related incidents, dialysis access malfunction, lymphedema following mastectomy, etc.)
- The use of an academic-practice partnership encourages expertise in evidence-based practice implementation at the bedside.

Link: https://library.amsn.org/amsn/sessions/3226/view

References:

PDC Healthcare Solutions. (2015). *Patient ID wristbands.* Retrieved from http://www.pdchealthcare. com/products/patient-id-wristbands.html#limit=27&mode=grid&order=ranking&dir=desc&p=5

Pennsylvania Patient Safety Advisory. (2005). *The color of safety: Standardization and implementation manual.* Retrieved from http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/wristbands/Documents/wristband_manual.pdf

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