Standardization of Color-Coded Wristbands in Washington State

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http://www.wsha.org/page.cfm?ID=0195


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Executive Summary

Overview

Washington hospitals provide very good care for patients. Yet, we know more needs to be done to make care safer. Across the nation, hospitals are looking for ways that they can reduce the risk of harm to patients. In reviewing adverse event data from across the nation, it was identified that some errors have come from the variation in the use of color-coded wristbands by hospitals. In December 2005, a patient safety advisory was issued that brought to light an incident that occurred in a hospital in which clinicians nearly failed to rescue a patient whose heart stopped because the patient was incorrectly designated as Do Not Resuscitate or "DNR."

The source of confusion was the different practices between hospitals on color-coded wristbands. A nurse placed a yellow wristband on a patient. In that hospital, a yellow wristband meant DNR. In the nearby hospital, where the nurse also worked, yellow meant "restricted extremity" which was what she was trying to communicate to other staff. Fortunately, another nurse recognized the mistake and the patient was resuscitated.

As a result, there is a national effort underway to standardize the colors and wording on wristbands.

A color-coded wristband is a means to convey or communicate important medical information or an alert about the status of a patient.

This binder is based on the national agreement of the colors that should be used by hospitals if they use color-coded wristbands. The Washington State Hospital Association is supporting this effort at the request of members who are looking for ways to reduce harm to patients. They believe this process is important because many of our staff and physicians work in multiple hospitals. The Washington State Nurses Association supports this effort.

As part of this process, the Washington State Hospital Association conducted a survey to measure the variation in use of color-coded wristbands in Washington hospitals.

Following are the survey results for Washington –

Types of Wristbands	Color	Percent of Washington Hospitals Already Using
Do Not Resuscitate (DNR)	**Purple**	50%
Allergy Alert	**Red**	76%
Fall Risk	**Yellow**	78%

These are the same colors which have been agreed to nationally and implemented in Arizona, California, Colorado, Nevada, New Mexico, Oregon, Utah, and now the state of Washington. The wristbands look like:

Do Not Resuscitate

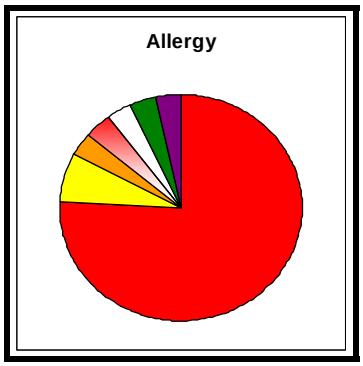
Allergy Alert

Fall Risk

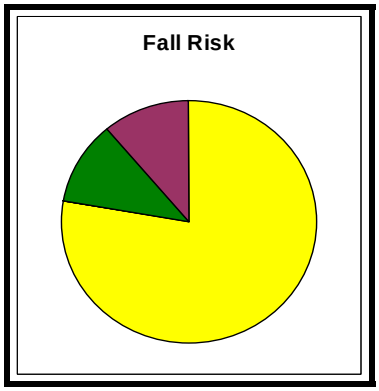
The information presented in this binder is not meant to encourage the use of color-coded wristbands, but to increase safety in those hospitals that use them.

Results of Color-Coded Wristbands Survey in Washington Hospitals

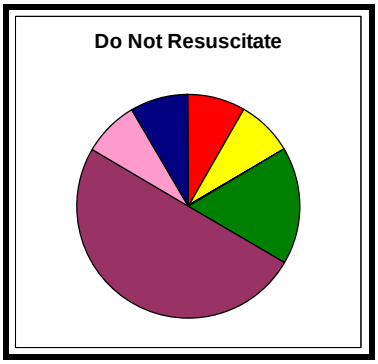
Allergy	Percentage of Time Hospitals Use This Color
Red	76%
Yellow	7%
Orange	3%
Clear	3%
Green	3%
Purple	3%
Red & White	3%



Fall Risk	Percentage of Time Hospitals Use This Color
Yellow	78%
Green	11%
Purple	11%



DNR	Percentage of Time Hospitals Use This Color
Red	8%
Yellow	8%
Green	17%
Purple	50%
Pink	8%
Blue	8%



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Colors for Adoption

Do Not Resuscitate

Allergy Alert

Fall Risk


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The Colors

Colors for Adoption

Recommendation:

Use purple for Do Not Resuscitate and label with "DNR" on the wristband.

Frequently Asked Questions

1. **Why did you select purple?**
   Purple was selected to be consistent with national models, which use the color purple to indicate DNR. It just made sense to continue with an established color that has been implemented in 15 other states including Arizona, Colorado, Nevada, New Mexico, Utah, Oregon, and California. The American Hospital Association is in the process of endorsing this color.

2. **Why have a wristband for DNR?**
   Registry and traveler staff may not be familiar with how to access information, when seconds count. It is also helpful as patients are moved between departments.

3. **If we adopt the purple DNR wristband then do we still need to look in the chart?**
   Code status should always be double checked with the chart so that the specific wishes of the patient and families can be honored i.e., no medication, no ventilator, etc.

4. **Why not use the color Blue?**
   Many hospitals use "Code Blue" to summon the resuscitation team. By also having the DNR wristband as "no code" there would be the potential to create confusion. "Does blue mean we code or do not code?" To avoid creating any second guesses in this critical movement, we opted not to use blue.

5. **Why not use Green?**
   Due to color blindness concerns it was decided to avoid green. Also, in other industries, the color green often has a "go ahead" connotation, such as traffic lights. We again want to avoid any possibility of sending "mixed messages" in a critical moment.

Colors for Adoption

Recommendation:

Use red for the Allergy Alert and label with "Allergy Alert" in the wristband.

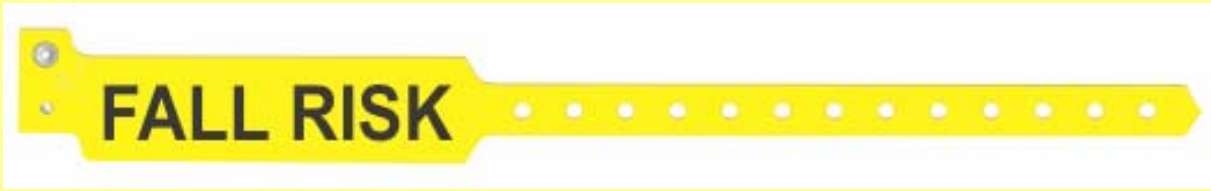
Frequently Asked Questions

1. **Why did you select red?**
   Red was selected to be consistent with the national models, which use the color red to indicate an allergy. It just made sense to continue with an established color that has been implemented in 15 other states including Arizona, Colorado, Nevada, New Mexico, Utah, Oregon, and California. The American Hospital Association is in the process of endorsing this color.

2. **Are there any other reasons for using red?**
   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 red to communicate "Stop!" or "Danger!" We think this message holds true for communicating an allergy status. When a caregiver sees a red allergy alert wristband they are prompted to "Stop!" and double check if the patient is allergic to the medication, food, or treatment they are about to receive.

3. **Do we write the specific allergies on the wristband too?**
   No, staff will double check specific allergy in the medical record. It is our recommendation that allergies be written in one location on the medical record. We suggest specific allergies not be written on the wristband for several reasons:
   - Legibility may hinder the correct interpretation of the allergy listed.
   - By writing allergies on the wristband, someone may assume the list is comprehensive and one might be omitted.
   - Throughout a hospitalization, allergies may be discovered by other caregivers such as dieticians, pharmacists, etc. This information is added to the medical recorded and not always a wristband. By having one source of information, staff of all disciplines know where to add or find allergies.

Colors for Adoption



Recommendation:

Use yellow for the Fall Risk Alert and label with "Fall Risk" on the wristband.

Frequently Asked Questions

1. **Why did you select yellow?**
   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.

2. **Why use an alert wristband for Fall Risk?**
   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:
   - More than a third of adults aged 65 years or older fall each year.
   - Older adults are hospitalized for ***fall-related injuries five times more often than they are*** for injuries from other causes.
   - Of those who fall, 20% to 30% suffer moderate to severe injuries that reduce mobility independence, and increase the risk of premature death.
   - The total cost of all fall injuries for people age 65 or older in 1994 was $27.3 billion.
   - For more information about falls and related statistics, go to: http://www.cdc.gov/ncipc/factsheets/fallcost.htm.

Falls account for more than 70 percent of the total injury-related health cost among people 60 and older.

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Policy and Procedure

Do Not Resuscitate

Allergy Alert

Fall Risk


Patient
Safety

Policy and Procedure Sample

Policy name: Color-Coded Wristbands

Purpose

To have a 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.

1. 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., "DNR", "Allergy Alert", or "Fall Risk")
   2. No handwriting is used on the wristband.
   3. Colored wristbands 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. 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.

2. Definitions

The following represents the meaning of each color-coded band:

Band Color	Communicates
Purple	Do Not Resuscitate (DNR)
Red	Allergy Alert
Yellow	Fall Risk

3. Identification (ID) Wristbands 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.

4. Color-Coded Hospital Wristbands

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 DNR, allergies, and falls 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 wristbands, 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 color-coded wristband, 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.
F. Patients wearing "DNR" or "Allergy" will have their medical records reviewed by staff to get additional information.

5. 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. To notify the nurse whenever a wristband has been removed and not reapplied; or
D. When a new band is applied and they have not been given explanation as to the reason.

8. Hand-Offs 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 on as a safety alert during transfer. Receiving facilities should follow their policy 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 order and Advanced Directives must occur. Order should be verified in the medical record prior to acting on the DNR.

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.

WSHA wishes to acknowledge the Pennsylvania Color of Safety Task Force, which developed the initial policy that is the basis for this document.

{Facility Name}
{Form Number}

Patient Refusal to Participate in the Wristband Process Sample

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 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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Staff and Patient Education Materials

Do Not Resuscitate

Allergy Alert

Fall Risk


Patient
Safety

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 health unit clerks are greatly involved in the system process. Include them in the training. They can better assist the nurses when they are included.
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 wristband 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. Include them in the process.
5. Who else? Take a few minutes to quietly observe the activities of the day at one of the nursing stations. In just a 30 minute observation and you will probably "see" and "hear" things that help identify another stakeholder. Include them in the education process. Once done, you can begin the actual training part.

Getting Started on Training

Most hospitals will use this document as the main content for the education on color-coded wristbands. It contains most of the pertinent information staff needs to know for this initiative.

Materials to help you as you do the training:

- Colors for Adoption (pages 5 – 7)
- Policies and Procedures (pages 9 – 12)
- Patient Refusal (page 13)
- Risk Reduction Strategies Quick Reference Card (page 21)
- Script for Staff to Talk with Patient or Family Member (page 23)
- Staff Poster Sample (page25)
- Staff Sign-In Sheet (page 27)
- Staff Competency Color-Coded Wristband Checklist Sample (page 29)
- Patient Flyer Sample (page 31)
- PowerPoint Presentation (pages 33)

Main Points of Training:

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?

The story below is true. A patient was almost not coded due to hospitals having different policies on colors of 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. 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 whose heart stopped beating because the patient had been incorrectly designated as "DNR" (do not resuscitate). The source of the confusion was that hospitals used different colors of wristband to mean different things. A nurse 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 for an IV. Fortunately, 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 this hospital for their disclosure of this event. It could have happened anywhere, and it has served as a "wake-up call" for other hospitals.

2 **Introduce the Colors –** There are the three different color-coded "alert" wristbands that we are going to discuss that are a part of national and statewide standardization. These wristbands have been adopted in many states including Arizona, Colorado, Nevada, New Mexico, Utah, Oregon, and California.

Do Not Resuscitate

Allergy Alert

Fall Risk

3 **Seven Risk Reduction Strategies** – In addition to the standardization of color-coded wristband colors in the state, we share seven other risk reduction strategies that can be initiated. These were created as a result of sentinel events that have occurred, near-miss events, and common sense. (See page 21)

4 **Teaching Patients -** 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 sample text on page 23 was written to serve as a "script" for staff to help deliver information to patients and families. By having a consistent message, we reinforce the information – this helps patients and families retain the information.

5 **And finally…. Review with staff the points listed below.** These are the items that are listed on the staff competency checklist so it is important to clarify that staff has 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 hospital's Policy & Procedure. Be sure your policy covers the areas listed below as they are also a part of the staff competency checklist. If your policy does not address any of the items on the staff competency checklist, then you should remove it from the list.

- ✓ Color code – what do the three colors mean?
- ✓ Who can apply the wristband to the patient?
- ✓ When does the application of the color-coded wristband(s) occur?
- ✓ Policy on not allowing patients to wear the "Social Cause" bands.
- ✓ Patient education and how to communicate (script) the information with patients/families.
- ✓ Need for re-application of wristband.
- ✓ Communication regarding wristbands during transfers and other reports.
- ✓ Patient refusal to comply with policy.
- ✓ Discharge instructions for home and/or facility transfer.

Go to WSHA's web site at www.wsha.org. Click on "Patient Safety," then "Communication Tools" for electronic copies of this toolkit.

Risk Reduction Strategies

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, or change in condition, or with new information during hospital stay.
5. Educate patients and family members regarding the wristbands.
6. Coordinate chart, white board, care plan, door signage information and stickers with same color coding.
7. Educate staff to verify patient color-coded "alert" wristbands upon assessment, hand-offs in care and facility transfer communication.

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

1. **Use wristbands that are pre-printed with text that tells what the wristband means.**
   - This can reinforce the color coding system for new clinicians, help caregivers interpret the meaning of the wristband in dim light, and also help those who may be color blind.
   - Eliminates the chance of confusing colors with alert messages.
2. **Remove any "social cause" (such as Live Strong, Cancer, etc.) colored wristbands.**
   - Be sure this is addressed in your hospital policy.
   - If that can't be done, you can cover the wristband with a bandage or medical tape, but removal altogether is best.
3. **Remove wristbands that have been applied from another facility.**
   - This should be done during the entrance to facility process and/or admission.
   - Be sure this is addressed in your hospital policy.

4. **Initiate banding upon admission, changes in condition, or with new information received during hospital stay.**

5. **Educate patients and family members regarding purpose and meaning of the wristbands.**
    - Including the family in this is a safeguard for you and the patient.
    - Remind them that color-coding provides another opportunity to prevent errors.
    - Use the patient/family education flier located in the toolkit.

6. **Coordinate chart, white board, care plan, door signage information, and stickers with same color-coding.**

7. **Educate staff to verify patient color-coded "alert" wristbands upon assessment, hand-offs in care and facility transfer communication.**

8. **When possible, limit the use of colored wristbands.**
    - Such as, for other categories of care (i.e. MRSA, tape).

9. **Remember, the wristband is a tool to communicate an alert status.**
    - Educate staff to utilize the patient, medical record information to verify and get more information.

10. **If your hospital 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 hospital.**

SCRIPT for Staff to Talk With a Patient or Family Member (Sample)

What is a Color-coded "Alert" Wristband?

Color-coded alert wristbands are used in hospitals to quickly communicate important information between staff regarding a condition a patient may have. This is done so every staff member can provide the best care possible.

What does the color of your wristband mean?

PURPLE means "DNR" or Do Not Resuscitate
Some patients have expressed an end-of-life wish and we want to honor that request.

RED means ALLERGY ALERT
If a patient has an allergy to anything - food, medicine, dust, grass, pet hair, etc. – the red wristband alerts us to look in your medical record to find out additional information. This helps us provide safe care.

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.

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Staff Poster (Sample)

Do Not Resuscitate

Allergy Alert

Fall Risk

Join us for an in-service on color coded wristbands

Day / Date / Time:
_____

Location:_____

Day / Date / Time:
_____

Location:_____

Day / Date / Time:
_____

Location:_____

Questions? Contact: _____ext:_____

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Staff Sign-In Sheet (Sample)

Date :_____ Unit/Dept/Location_____

Educator: _____

Topic: **Color-Coded Alert Wristbands**

Objective:

1. **To inform staff of the new process and colors of the DNR, Allergy Alert, and Fall Risk color-coded 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:_____

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Staff Competency Color-Coded Wristband Checklist (Sample)

Purpose: These are the standards of the technical competencies.

To meet competency standards, the employee must demonstrate proficiency in performing the technical procedures safely as evidenced by department specific criteria.

Methods to Use:

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

Supervisor's initials signify competency was met.

Employee Name Job Title

Patient Color-Coded Alert Wristband Process	Date	Method Used	Supervisors Initials	Comments
Color Code – what do the three colors mean?				
Who can apply the wristband to the patient?				
When does the application of the 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 wristband				
Communication regarding wristbands during transfers and other reports				
Patient refusal to comply with policy				
Discharge instructions for home and /or facility transfer				

Supervisor Signature Initials/Date Employee Signature Initials/Date

WSHA acknowledges the Pennsylvania Color of Safety Task Force, which developed the initial policy as the basis for this document.

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Patient Flier (Sample)

Statewide Patient Safety Initiatives

Patient safety is a top priority for Washington. 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 nationally including Oregon and California.

What is a Color-coded "Alert" Wristband?

A color-coded wristband is a means to convey or communicate important medical information or an alert about the status of a patient. 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?

PURPLE means "DNR" or Do Not Resuscitate

Some patients have expressed an end-of-life wish and we want to honor that.

RED means ALLERGY ALERT

If you have an allergy to anything – food, medicine, dust, grass, pet hair, etc. ANYTHING – tell us. It may not seem important to you but it could be very important in the care you receive.

YELLOW means FALL RISK

We want to prevent falls at all times. Sometimes, a person may become weakened during their illness or surgery.

Involving Patients and Family Members

Washington health care providers are working together to make patients safe. We accomplish this goal by working together on projects like using the same color-coded wristbands.

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.

"Zero errors that affect patient's health"

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PowerPoint Presentation

This presentation was created to provide alternate teaching methods for nurses and to educate department leaders and senior management.

Speaker notes can be viewed at the bottom of each page.

Please go to http://www.wsha.org/files/82/Wristband_presentation.ppt to access the presentation.

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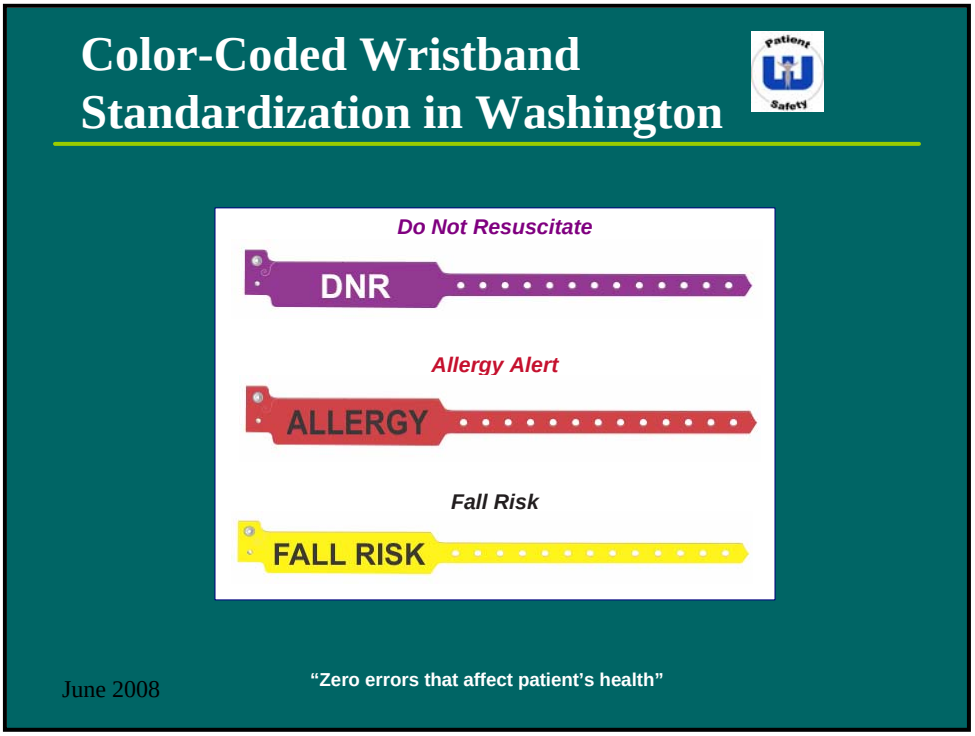


Welcome. Today we will be sharing one way in which Washington hospitals are working together to reduce harm to patients.

I will be sharing:
•Why wristband standardization is important.
•What colors we will be using.
•What you need to know in order to take care of patients.

Overview

- Pennsylvania had a 'near miss' when a nurse, who worked in multiple hospitals, used the wrong color wristband for DNR.
- This is a national initiative with many states including Arizona, Colorado, New Mexico, Utah, Oregon, California.
- Washington hospitals with the support of the Washington State Hospital Association are collaborating to implement standard color-coded wristbands.

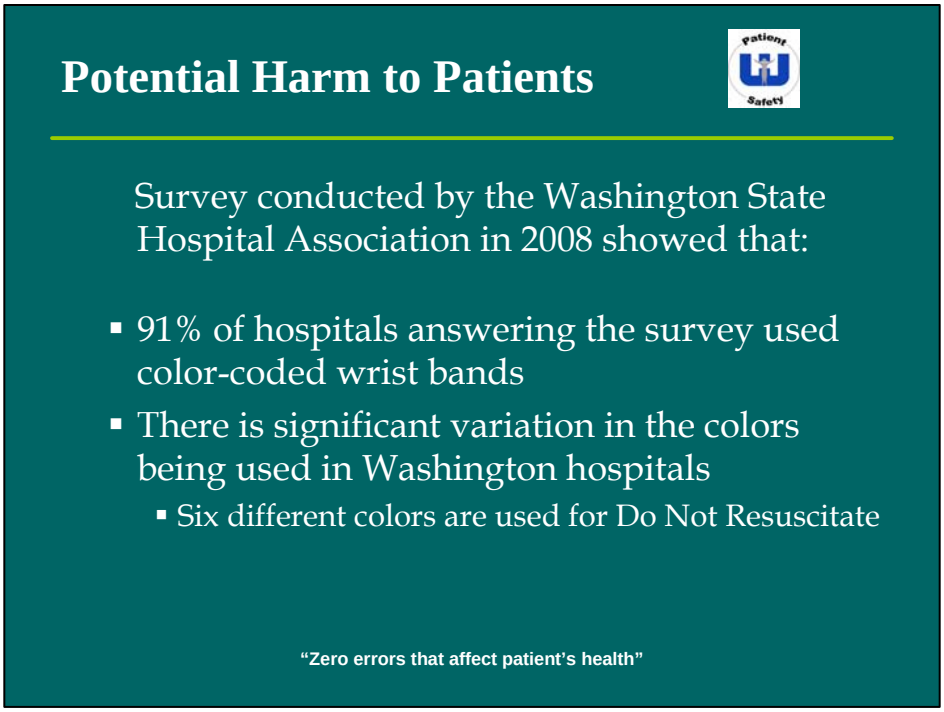
"Zero errors that affect patient's health"

Washington hospitals provide very good care for patients. Yet, we know more needs to be done to make care safer. Across the nation, hospitals are looking for ways that they can reduce the risk of harm to patients. In reviewing adverse event data from across the nation, it was identified that some errors have come from the variation in use of color-coded wristbands by hospitals. In December 2005, a patient safety advisory was issued that brought to light an incident that occurred in a hospital in which clinicians nearly failed to rescue a patient whose heart stopped because the patient was incorrectly designated as Do Not Resuscitate or "DNR."

The source of confusion was the different policies between hospitals on color-coded wristbands. A nurse placed a yellow wristband on a patient. In that hospital, a yellow wristband meant DNR. In the nearby hospital, where the nurse also worked, yellow meant "restricted extremity" which was what she was trying to communicate to other staff. Fortunately, another nurse recognized the mistake and the patient was resuscitated.

As a result, there is a national effort underway to standardize the colors and labels on wristbands.

A color-coded wristband is a means to convey or communicate important medical information or an alert about the status of a patient.



The Washington State Hospital Association is supporting this effort at the request of members who are looking for ways to reduce harm to patients. They believe this process is important because many of our staff and physicians work in multiple hospitals.

As part of this process, the Washington State Hospital Association conducted a survey to measure the variation in use of color-coded wristbands in Washington hospitals.

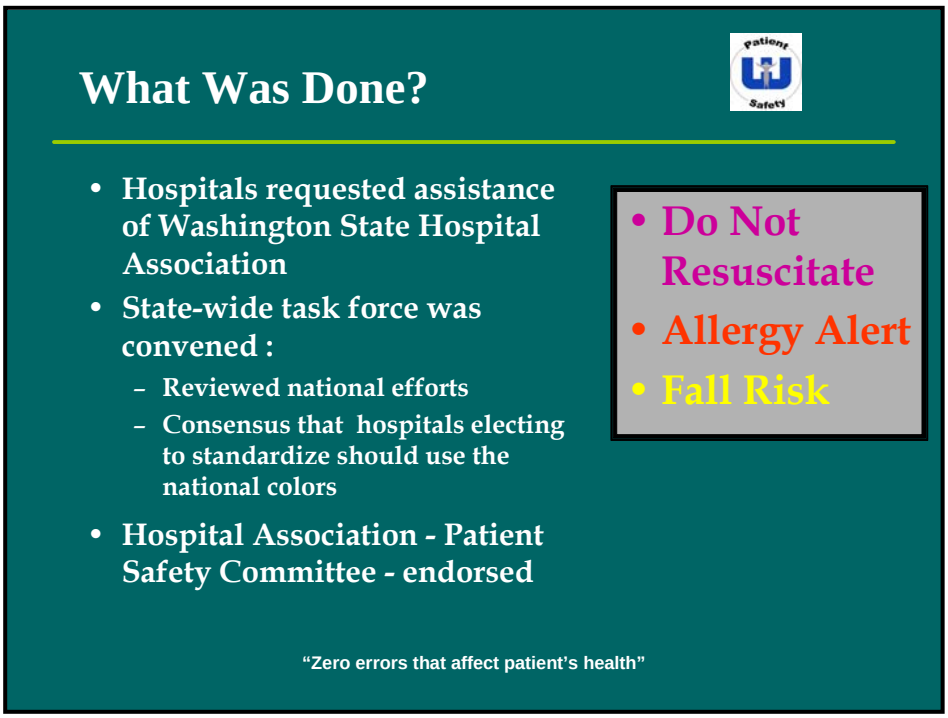
A survey was conducted that found significant differences in the colors of wristbands used in Washington. For example, there were six different colors used for "DNR" or Do Not Resuscitate.

Impact to Staff, Physicians, and Patients

- Many physicians and nurses work in multiple hospitals.
- Variation leads to confusion and the potential of errors to patients.
- Variation makes the jobs of nurses, physicians and other staff more difficult.

"Zero errors that affect patient's health"

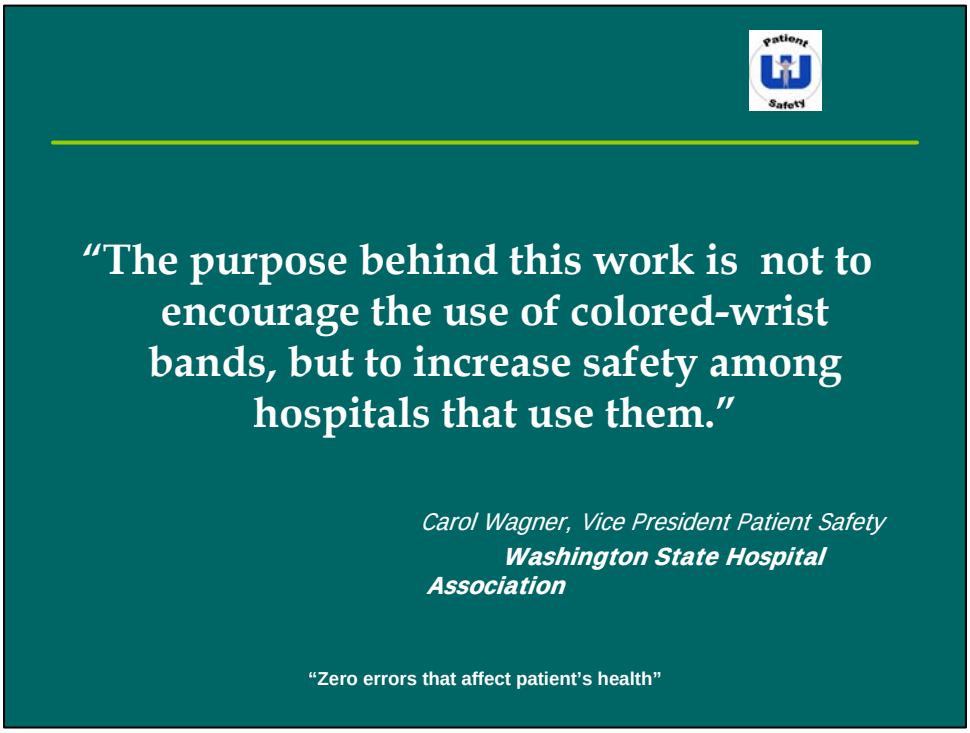
The variation in wristband color makes it more difficult for staff and physicians who train and work in multiple hospitals. There is potential harm which hospitals can eliminate by standardizing the color of wristbands they use.



Hospitals in Washington have asked for assistance from the Washington State Hospital Association in implementing the national standards for color-coded wrist bands. Representatives from large and small hospitals from across the state participated in reviewing the national efforts. They came to consensus that hospitals in Washington should move to use the national standards.

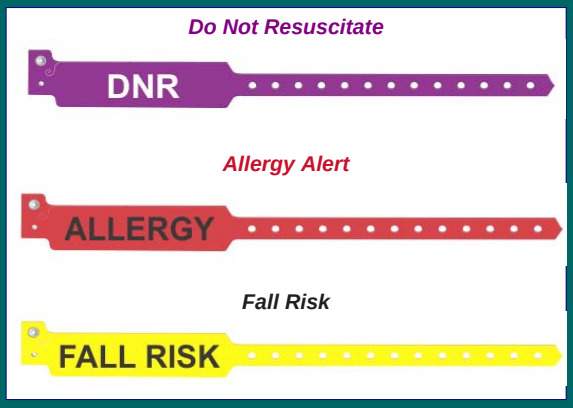
Our hospital is changing our processes to use these standard colors like many other hospitals are doing across Washington.

Our goal is to make it easier for physicians and staff care to provide safe care for patients.



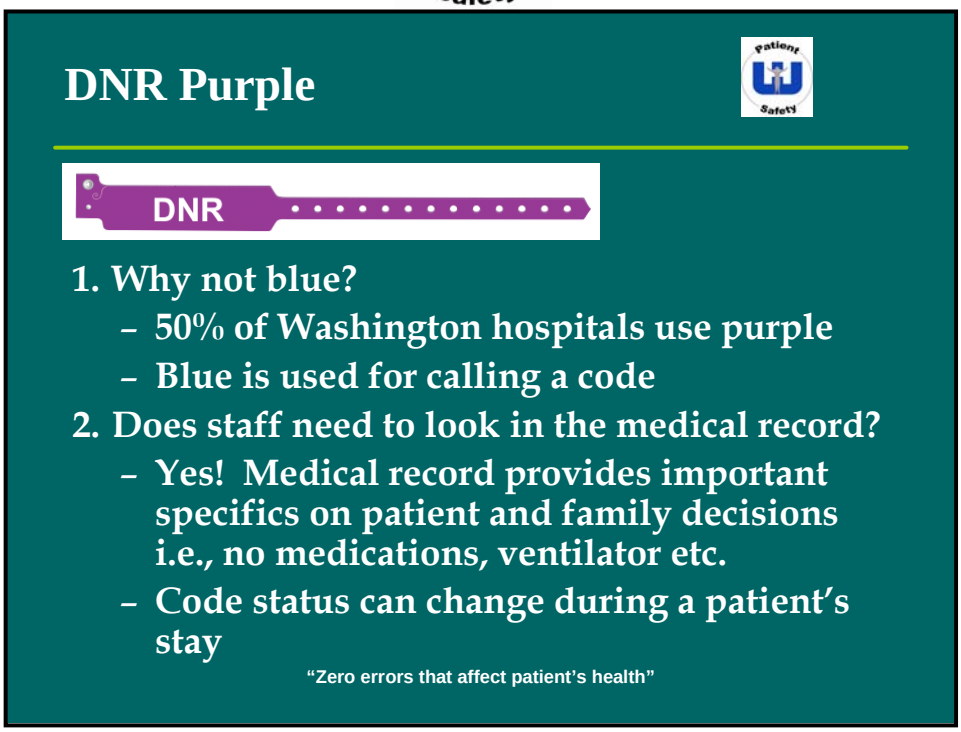
The purpose of this work is not to encourage the use of color-coded wristbands, as some hospitals have other ways of communicating…it is to increase safety among hospitals that use them.

Selected Colors



"Zero errors that affect patient's health"

The wristband colors we will be using are:
Purple - Do Not Resuscitate
Red - Allergy Alert
Yellow - Fall Risk



Purple - Do Not Resuscitate designation

Why purple?

Purple was selected to be consistent with national models, which use the color purple to indicate DNR. It just made sense to continue with an established color that has been implemented in 15 other states including Arizona, Colorado, Nevada, New Mexico, Utah, Oregon, and California. The American Hospital Association is in the process of endorsing this color.

Why have a wristband for DNR?

Registry and traveler staff may not be familiar with how to access information, when seconds count. It is also helpful as patients are moved between departments.

Do we still need to look in the chart?

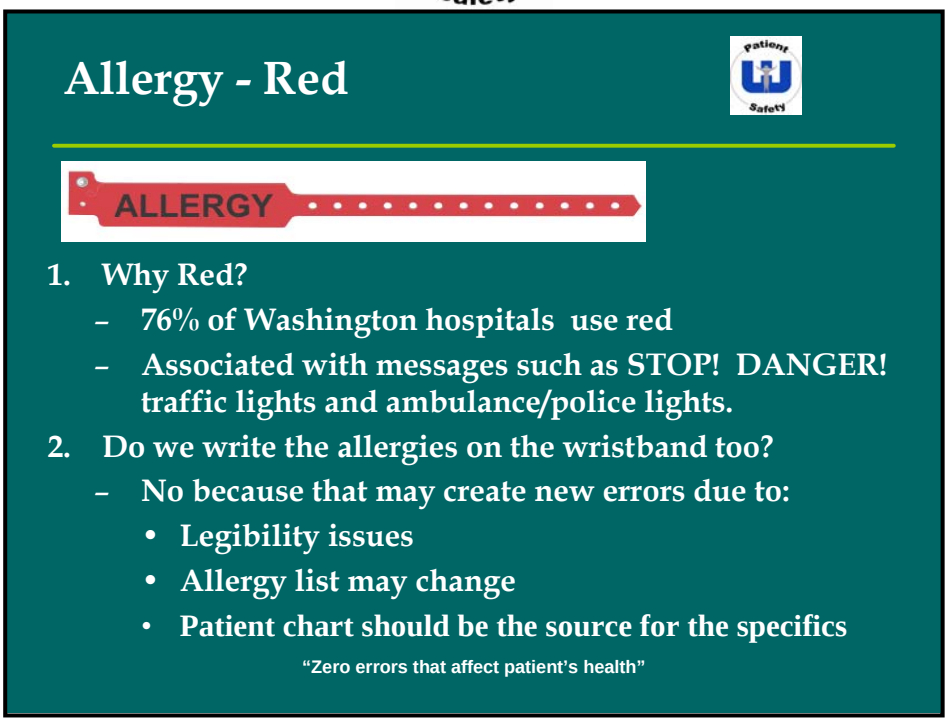
Code status should always be double checked with the chart so that the specific wishes of the patient and families can be honored i.e., no medication, no ventilator, etc.

Why not use the color Blue?

Many hospitals use "Code Blue" to summon the resuscitation team. By also having the DNR wristband as "no code" there would be the potential to create confusion. "Does blue mean we code or do not code?" To avoid creating any second guesses in this critical movement, we opted not to use blue.

Why not use Green?

Due to color blindness concerns it was decided to avoid green. Also, in other industries, the color green often has a "go ahead" connotation, such as traffic lights. We again want to avoid any possibility of sending "mixed messages" in a critical movement.



Red – Allergy Alert designation

Why did you select red?

Red was selected to be consistent with the national models.

Are there any other reasons for using red?

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 this message holds true for communicating an allergy status. When a caregiver sees a red allergy alert wristband they are prompted to "Stop!" and double check if the patient is allergic to the medication, food, or treatment they are about to receive.

Do we write the specific allergies on the wristband too?

If a patient has a yellow allergy wristband, staff should look in the medical record to get additional details. All allergies should be written in the medical record. Specific allergies should not be written on the wristband for several reasons:

- Legibility may hinder the correct interpretation of the allergy listed.
- By writing allergies on the wristband, someone may assume the list is comprehensive and one might be omitted.
- Throughout a hospitalization, allergies may be discovered by other staff such as dieticians, radiologists, pharmacists, etc. This information is typically added to the medical recorded and not always a wristband. By having one source of information to refer to, such as the medical record, staff of all disciplines know where to add or find newly discovered allergies.

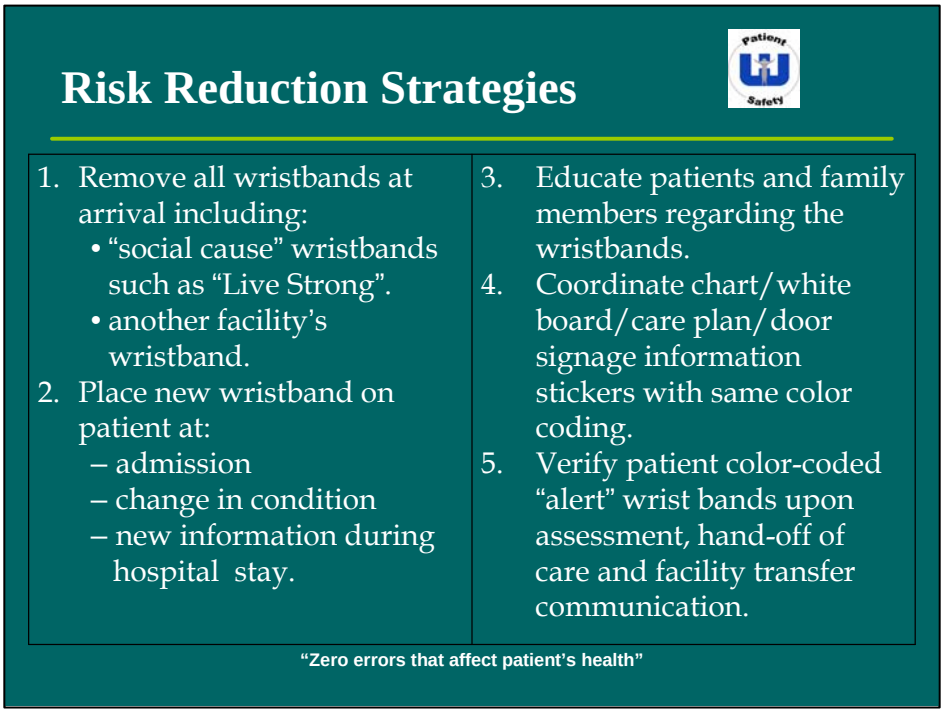
Yellow - Fall Risk

Why did you select yellow?

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.

Why use an alert wristband for Fall Risk?

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: More than a third of adults aged 65 years or older fall each year. Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes.



Staff should:

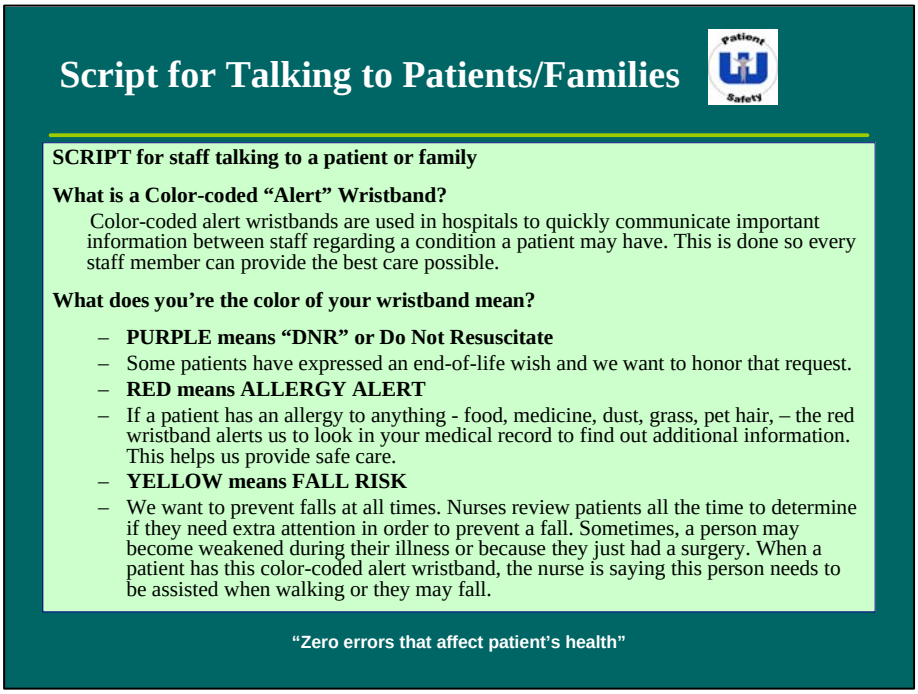
- **Remove all wristbands at arrival including:**
  - "social cause" wristbands such as "Live Strong".
  - another facility's wristband.

- **Place new wristband on patient at:**
  - admission
  - change in condition
  - new information during hospital stay.

- **Educate patients and family members regarding the wristbands.**

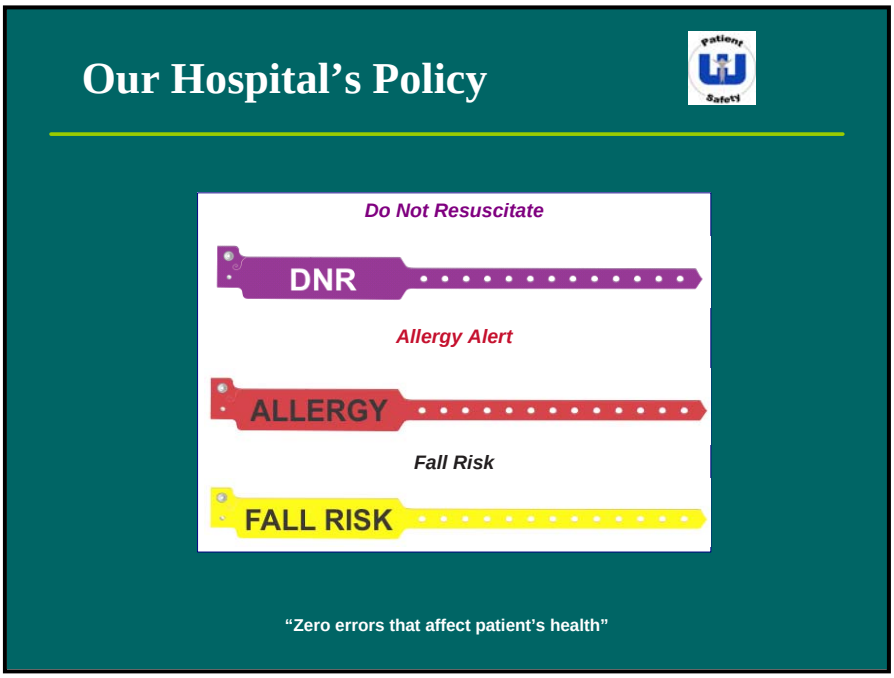
4. **Coordinate chart/white board/care plan/door signage information stickers with same color coding.**

5. **Verify patient color-coded "alert" wrist bands upon assessment, hand-off of care and facility transfer communication.**

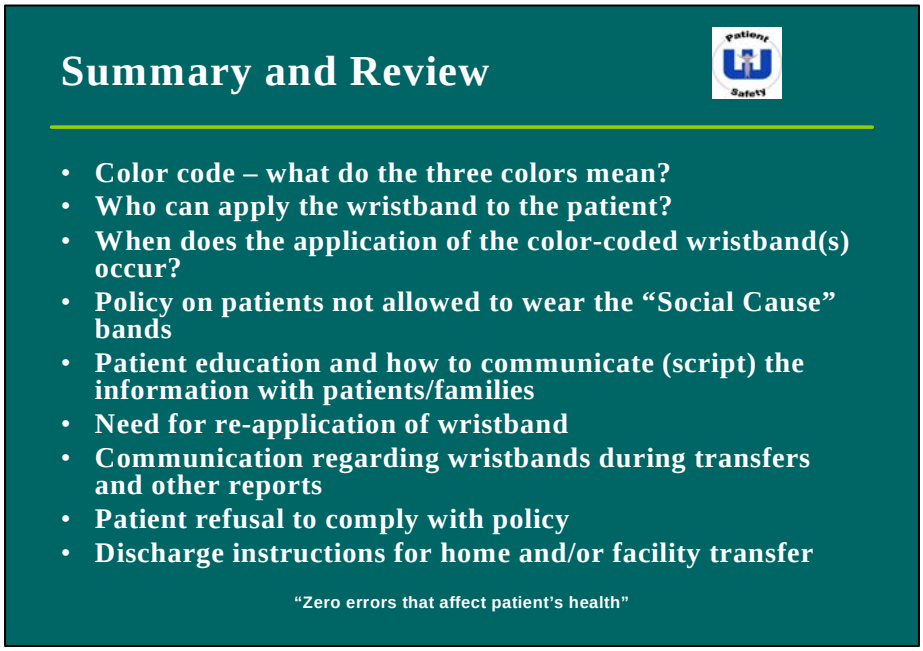


Teaching Patients - We know that ***how*** we say something is just as important as ***what*** we say. Patients and their loved ones are scared, vulnerable and unfamiliar with hospital ways. We need to communicate to them in a respectful and simple way without being condescending. The following text was written to serve as a "script" for staff and help deliver similar information to patients and families. By having a consistent message, we reinforce the information – this helps patients and families retain the information.

SCRIPT for staff talking to a patient or family
What is a Color-coded "Alert" Wristband?
Color-coded alert wristbands are used in hospitals to quickly communicate important information between staff regarding a condition a patient may have. This is done so every staff member can provide the best care possible.
What does you're the color of your wristband mean?
PURPLE means "DNR" or Do Not Resuscitate
Some patients have expressed an end-of-life wish and we want to honor that request.
RED means ALLERGY ALERT
If a patient has an allergy to anything - food, medicine, dust, grass, pet hair, – the red wristband alerts us to look in your medical record to find out additional information. This helps us provide safe care.
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.

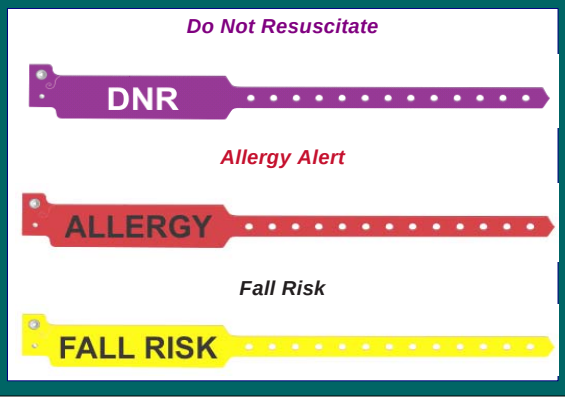


Review your hospital's policy and form for what to do if a patient refuses.



Review the above questions.

When You Should Begin Using



Enter Date:

"Zero errors that affect patient's health"

Discuss your implementation process.

Questions?

Contact _____ if you have additional questions.

"Zero errors that affect patient's health"

Time for questions and who to contact if questions.

Work Plan –
How to Implement

Do Not Resuscitate

Allergy Alert

Fall Risk


Patient
Safety

Suggested Work Plan

Area # 1

Hospital Approval
See Task Chart for specific steps

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.

Area #2

Supplies Assessment and Purchase
See Task Chart for specific steps

Review

~ Assessment of current supply ~ Wristband procurement

Action Plan

Most organizations have a vendor they are using for wristbands. 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 wristband (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.

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 (continued)

Area # 3

Hospital Specific Documentation

Review

~ Policy adoption **~ Assessment Revision**
~ Forms revised to meet standards **~Consents**

Action Plan

Color-banding policy should be reviewed and approved if changes are made.

Hospitals should review their respective forms for possible modifications (patient education assessments, etc.). You may want to include language that the patient received the wristband education flier (See Patient Education section).

If a patient refuses to wear a wristband, do you have a document indicating this? Perhaps this needs to be discussed at Policy and Procedure committee. A sample has been provided in toolkit.

Coordinate with: Risk Management Staff and individual Hospital Administrators

Area # 4

Staff and Patient Orientation, Education and Training

Review

~ Schedule/training content **~ Documentation requirement** **~ Posters & FAQs**

Action Plan

Education format and training materials 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

Task Chart for Hospital Preparation

Task Chart for Hospital Preparation			
Area # 1 Organizational Approval & Awareness			
Step 1	When: **Week One**		enter date this is done:
What to Do	Notes/Comments/Follow-ups		
Schedule presentation NOTE: Not all committees will need to approve this initiative. They will usually benefit from a presentation that provides information so they can support it. Seek guidance from your Administrative team to determine which meetings this needs to be presented to.	**Committee/ Presentation Date**	**Name**	**Email/ext.**
	Patient Safety		
	Medical Staff		
	Nursing Practice Council		
	Quality Council		

Task Chart for Hospital Preparation			
Area # 1 Organizational Approval & Awareness (continued)			
Step 2	When : **Pending Committee Approvals**		
What to Do	Notes/ Comments/Follow-ups		
After presentations made and approval obtained to adopt recommendations, contact pertinent department/staff to move forward, and convey appropriate information.	**Dept.**	**Info to be conveyed**	**Follow-ups**
	Materials Management	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. (Allows for distribution of wristbands to pertinent areas.)	**How long until delivery?**
	Staff Education	1. Wristbands will be arriving in about _____ weeks. 2. "Go Live" Date is _____ 3. OK to start education.	
	Risk Mgmt and/or QI Director	1. Wristbands will be arriving in about _____ weeks. 2. "Go Live" date is _____ 3. Confirm Policy and Procedure is approved and in manual.	
	Medical Staff, Admitting, ED, Peri-Op, pharmacy, Lab, Dietary, Radiology, etc.	1. Wristbands will be arriving in about _____ weeks. 2. "Go Live" Date is _____ 3. OK to start education. Coordinate with Education Dep.	

Task Chart for Hospital Preparation (continued)

Task Chart for Hospital Preparation	
Area # 2 Supplies Assessment and Purchase	
Step 1 When: **Week One** enter date this is done:	
What to DO	Other Notes/Cues
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.	Coordinated with Materials Management the person who will do the ordering. Name: _____ Email: _____ Phone:_____
Step 2 When: Week One	
What to DO	Other Notes/Cues
Ask Materials Manager when current supply of wristbands will run out. This is based on estimates from typical order patterns and staff usage.	Allergy Bands run out _____ (ex: mid-Jan. 08) Fall Bands run out about _____ DNR Bands run out about _____
Step 3 When: Week One	
What to DO	Other Notes/Cues
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.	**DNR Wristband:** □ Purple: PMS 254 □ "DNR" pre-printed on wristband in white – 48 pt. Arial Bold, all caps **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
Step 4 When: Week One	
What to DO	Other Notes/Cues
Follow-up with Materials Management in a week and validate that they were able to contact vendor. Complete info in right column from Materials Management.	Lead time required when ordering wristbands is: DNR Wristband: _____ weeks ALLERGY Wristband: _____ weeks FALL Wristband: _____ weeks

Task Chart for Hospital Preparation (continued)

Task Chart for Hospital Preparation	
Area # 3 Hospital Specific Documentation	
Step 1 When: **Week Two or Three** enter date this is done:	
What to DO	Other Notes/Cues
Contact chief nursing officer and clinical directors to review if documentation records contain specific information about wristbands, such as daily nursing charting. *Remember: This is not a recommendation to add "wristbands" to your documentation process or color specific information, but to review your current documents / process*	Coordinate with chief nursing officer 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:_____
Step 2 When: **Week Two or Three**	
What to DO	Other Notes/Cues
If your current documentation addresses wristband information, review documents to assure any reference to colors are updated to reflect these changes.	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.
If changes are required to the documentation forms, contact Forms Committee and pertinent clinical directors and initiate process for changes.	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.
Step 3 When: **Week Two or Three**	
What to DO	Other Notes/Cues
Once process is known, and if a form(s) update is required, factor the print time and new form availability into the time line so the education and implementation processes are in sync with the arrival of new documents.	

Task Chart for Hospital Preparation (continued)

Task Chart for Hospital Preparation	
Area # 3 Hospital Specific Documentation	
Step 4 When: **Week Four**	
What to DO	Other Notes/Cues
The Policy & Procedure (P & P) for wristband application needs to be reviewed and updated to reflect the new process. Obtain a copy of the current wristband Policy & Procedure and review content.	A sample P & 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 & P and determine what elements you will change. The sample P & P is not prescriptive but rather suggestive.*
Step 5 When: **Week Four**	
What to DO	Other Notes/Cues
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 and the proposed changes.	**Contact ED Director. Name/ext:** _____ **Unique P&P? No_____ Yes_____ (obtain copy)** **Contact Peri-Op Director. Name/ext:** _____ **Unique Policy and Procedure? No_____ Yes_____ (obtain copy)** **Contact Radiology Director. Name/ext:** _____ **Unique Policy and Procedure? 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)**
Step 6 When: **Week Four**	
What to DO	Other Notes/Cues
Get this item on P & P Committee agenda and have approval for the changes. Coordinate this with the departments that have "unique" P & P so all are changed at the same time.	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.

Task Chart for Hospital Preparation (continued)

Task Chart for Staff / Patient Education	
Area # 4 Staff and Patient Education	
Step 1 When: **Two or Three** weeks	
What to DO	Other Notes and Cues
Familiarize yourself with training content and the tools (Frequently Asked Questions & fliers)	Review the contents of the Education session in this toolkit. 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.
Step 2 When: **Two or Three** weeks	
What to DO	Other Notes and Cues
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? *It is important to consider all of the stakeholders: physicians, dietary, pharmacy, therapies, radiology, peri-Op, ED, L&D, housekeeping, etc. The column on the right is a tool that you will need for all of the stakeholders. Use the back of this if more room is needed.*	**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 _____) Facilitator Preferences: _____ Unit Based _____ Educ Dept.
Step 3 When: **Three or Four** weeks	
What to DO	Other Notes and Cues
Familiarize yourself with training content and the tools (Frequently Asked Questions & fliers) 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.*	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.

Task Chart for Hospital Preparation (continued)

Task Chart for Staff / Patient Education	
Area # 4 Staff and Patient Education continued	
Step 4 When: **Three or Four** weeks	
What to DO	Other Notes and Cues
Find out the name of Chair of the "Patient / Community Education" Committee. Contact that person and schedule an 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**	
What to DO	Other Notes and Cues
Make one copy of the Education section of this toolkit for each trainer so they each have their own set of materials. Don't forget about the PowerPoint presentation too.	Go to WSHA's web site at www.wsha.org. Click on "Patient Safety," then "Tools." The toolkit can be found under the "Washington Color-coded Wristband Implementation" heading.
Step 6 When: Three weeks before Staff Education Roll-out	
What to DO	Other Notes and Cues
Send out a reminder email to all trainers reminding them to make copies of the following hand outs for their staff: ~ Staff education documents ~ Patient education flier ~ Frequently Asked Questions ~ Posters announcing the meeting ~ 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 and pink "props" or candy – like M&Ms, Skittles or other such items.

A Few Vendors – Others Can be Used

The St. John Companies 25167 Anza Drive Valencia, CA 91355 Karen Joseph, Senior Product Manager, Patient Identification /Patient Safety 800-435-4242 www.patientIDexpert.com	Allergy Fall Risk DNR	Red — WBCALA-5 Red Narrow — WBCNAA-5 Yellow — WBCFRA-3 Yellow Narrow — WBCNFA-3 Purple — WBCDNA-8 Purple Narrow — WBCNDA-13 Purple Dove — WBCDVA-13
Standard Register P.O. Box 1167 Dayton, OH 45401-1167 Sherry Bannister, Label Product Marketing Manager 937-221-1299 office 800-755-6405 www.standardregister.com	Allergy Fall Risk	
EndurID 360 Merrimack Street, Building 9 Lawrence, MA 01843 Robert Chadwick, President 866-372-6585 www.endurid.com	Allergy Fall Risk	Multiple choices available
Posey 5635 Peck Road Arcadia, CA 91006 Jim Minda, District Manager 412-779-6667 800-447-6739 minda4@comcast.net	Allergy Fall Risk	Red 6247R — Embossed with “Allergy” Yellow 6247Y — Embossed with “Fall Risk”
PDC (Precision Dynamics Corporation) 13880 Del Sur Street San Fernando, CA 91340 Marilin Miller, SE Regional Sales Manager 800-847-0670 x 5150 www.pdccorp.com	Allergy Fall Risk	Multiple choices available — Embossed with “Allergy” Multiple choices available — Embossed with “Fall Risk”

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