

THE COLORS OF SAFETY

ACROSS THE CONTINUUM OF CARE

November 15, 2007



CONTINUING CARE LEADERSHIP COALITION



Timeline

- April 2007: CCLC Membership meeting
 - Discussed national landscape & survey results
 - Consensus to develop pilot & DOH support
- June 2007: GNYHA-CCLC Steering Committee meeting
 - Discussed survey, implementation & outcomes
 - Chose three alert conditions and colors
- November 15, 2007: Kick-Off Briefing

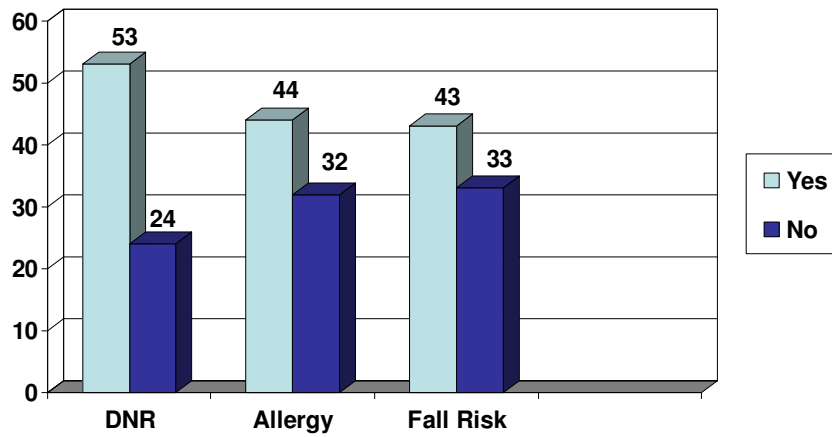
The National Landscape

National Initiatives

November 13, 2007

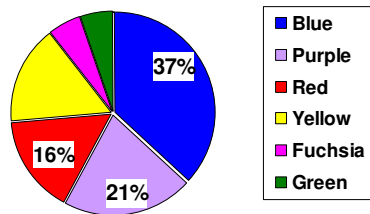
	AZ	CA	CO	MN	MO	NJ	NM	OH	OR	PA	WV
DNR	Purple	Purple	Purple	Purple	Purple	Purple	Purple	Nothing	Purple	Blue	Purple
Allergies	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
Fall Risk	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Latex Allergy				Green		Green				Green	
Restricted Extremities				Pink		Pink			Pink	Pink	

Current Color Coding in Hospitals and LTC Organizations (n = 77)

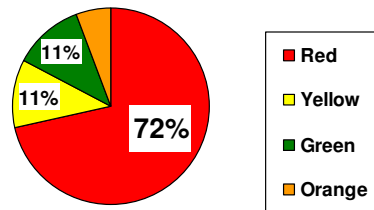


Hospitals

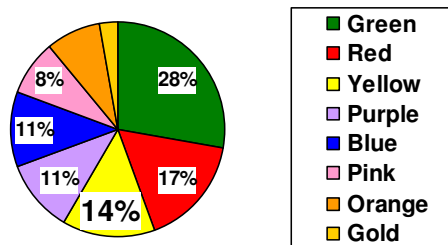
DNR (n = 19)



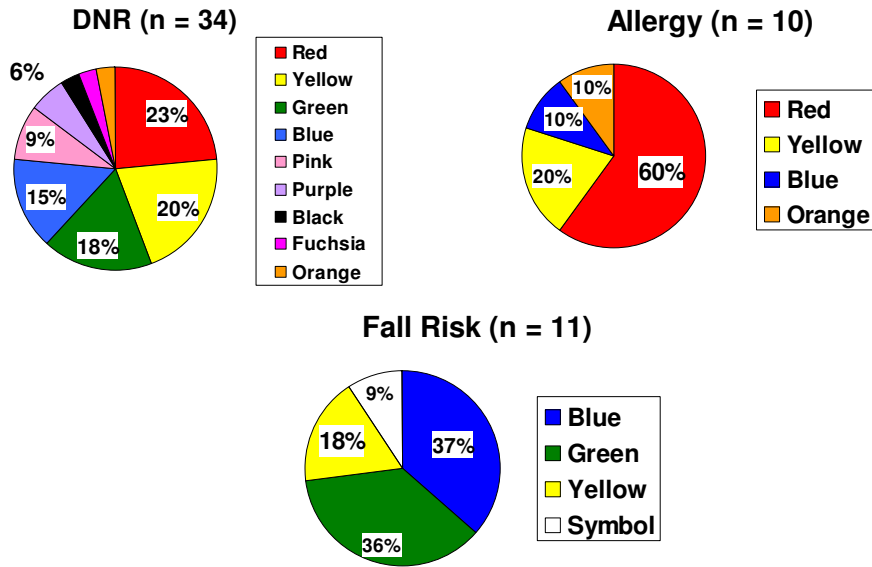
Allergy (n = 35)



Fall Risk (n = 32)

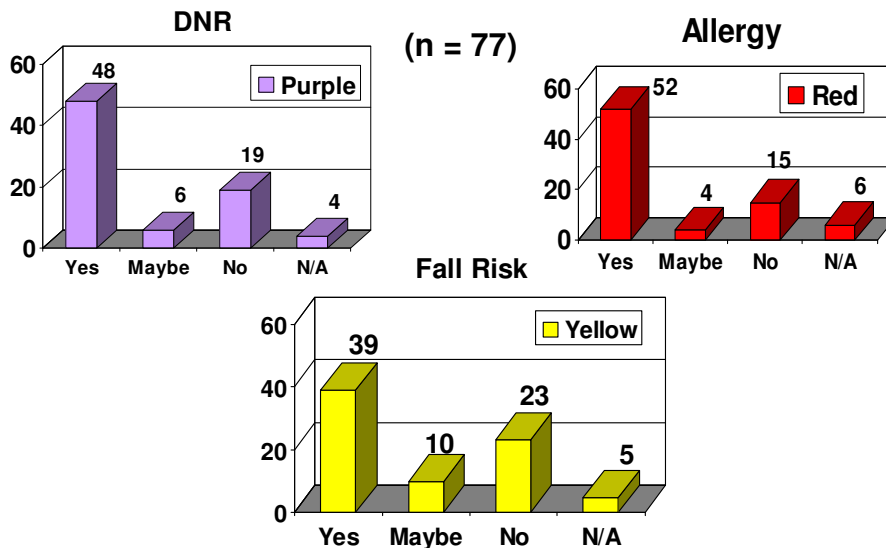


Long Term Care Organizations

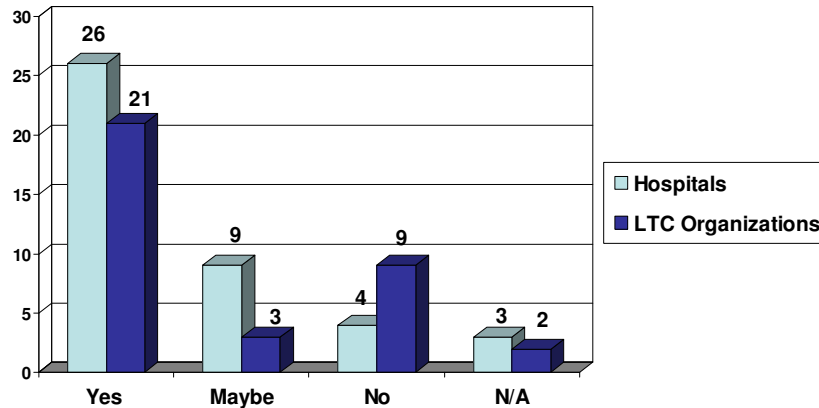


If the following three colors were standardized for the below alert conditions, would your organization adopt these colors?

Hospitals and LTC Organizations



Members Interest for 3 Alert Conditions and Colors



GNYHA-CCLC Initiative

The Colors of Safety Across the Continuum of Care

Alert Condition	Color
Do Not Resuscitate (DNR)	Purple
Allergies	Red
Fall Risk	Yellow

The Colors of Safety

Across the Continuum of Care

Purpose:

To increase patient safety by standardizing the color-coding of specific alert conditions across the acute and long term care health care settings.

DOH Participation & Support

Tool Kit

- Background of Initiative
- Goals and Objectives
- Strategies for Implementation
- Training and Education
- Resources
- GNYHA-CCLC Questionnaire
- Materials for Implementation
 - For Staff, Patients/Residents, and Family

Strategies for Implementation

- With patients consent, at the time patients and/or residents are admitted to the facility, remove all wristbands that they are wearing.
- If a patient, resident, or family member refuses to remove the band(s), explain potential for errors and cover the wristband with a bandage or medical tape.

Strategies for Implementation

- To avoid misinterpretation, a facility may choose to use **pre-printed text**:
 - Reinforce the color-coding system for new employees.
 - Minimize inaccuracies in dimly lit areas.
 - Avoid misunderstanding by color-blind health care providers.

Strategies for Implementation

- If there is concern about a patient's skin integrity or other medical condition, consider using alternatives to color-coded wristbands.
 - Color-coded dots in strategic places or on medical records.
- Staff should periodically verify the accuracy of wristbands and other means of identifying alert conditions with the medical record and patient/resident/family. Always check the medical chart.

Strategies for Implementation

- Consider incorporating color-coding into the nursing assessment to confirm or reconfirm alert conditions during hand-offs and for change-of-shift.
- Make sure that facility policies indicate clearly which categories of staff are authorized to place wristbands on patients/residents.

Strategies for Implementation

- Reinforce that all staff have the responsibility to promptly correct errors in identification of alert conditions.
- Educate patients and family members.

Measurement

- Colors being used for three alert conditions.
- Staff satisfaction:
 - Reduce time needed to orient staff.
 - Lead to improved staff satisfaction.
 - Improved patient outcomes.
- Reduction in medical errors.

Training and Education

- Ongoing communication
- GNYHA and CCLC have created materials to distribute to your staff, patients, and family members.

Privacy Issues

Next Steps