



# STATE OF NEW YORK DEPARTMENT OF HEALTH

Coming Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.  
Commissioner

Wendy E. Saunders  
Chief of Staff

November 15, 2007

Lorraine Ryan  
Special Counsel  
Greater New York Health Association  
555 West 57th Street  
New York, New York 11019

Dear Ms. Ryan:

Several states, as well as Greater New York Hospital Association (GNYHA), have amply documented the lack of uniformity that exists among organizations in the use of colors to signify important patient directives and medical conditions. While the intent of these color schemes and tools is to keep patients safe they can, unfortunately, have unintended consequences if caregivers and discharge planners are not clear about or confuse their meanings. These unintended consequences can result from staff turnover, organizational variation in the use of colors and human error. It requires a systems fix.

Accordingly, the New York State Department of Health commends and congratulates GNYHA and the Continuing Care Leadership Coalition (CCLC) for developing *The Colors of Safety Across the Continuum of Care* program and bringing together both hospitals and nursing homes to address this important problem. We will encourage other hospitals and nursing homes to adopt consistent color schemes as this can only serve to further reduce the variation in color schemes being utilized. We are confident that this program will create an important opportunity to improve patient safety. Our ultimate goal is for contiguous states to also adopt consistent schemes.

We especially appreciate your recommendations that should be considered as facilities implement *The Colors of Safety Across the Continuum of Care* program. These include the inclusion of concise, pre-printed text on wristbands to further reinforce what is intended to be communicated by these colors as well as properly educating staff, patients and family members on the purpose of this program. Lastly, we feel it is especially important that facilities have written policies and procedures in place regarding who applies wristbands, how frequently patients' needs are reassessed and how wristbands will reflect reassessments and what happens to wristbands upon discharge. We would also encourage hospitals to undertake Plan Do Study Act (PDSA), that will result in compliance and, more importantly, outcome monitoring of these important policies and procedures.

We look forward to participating in your ongoing evaluation and discussing useful refinements to the program to best meet the safety needs of patients.

Sincerely,



John Morley, M.D.  
Medical Director  
Office of Health Systems Management



Robert W. Barnett  
Director  
Patient Safety Center