Color-Coded Wristbands: Promoting Safety or Confusion?

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A 62-year-old man was transferred from an outside hospital for evaluation of a complicated spinal infection. Like many patients, he had color-coded wristbands to help identify potential safety hazards (see Fig. 1). The patient, an educated and



FIGURE 1. A hospitalized patient with several color-coded wristbands and unclear indications for each of them.

alert individual, could describe the indications for only 3 of the 5 wristbands, and the transferring hospital supplied no legend. As it turned out, the green band represented a fall risk, the red one a drug allergy alert, and the purple one a tape allergy, whereas the white one was for patient identification. We're still not certain what the yellow one represented, but it was not a Lance Armstrong "Livestrong" bracelet; such wristbands have been reported to cause confusion in hospitals that have adopted yellow for their "do not resuscitate" wristbands.1 Although attempts at ensuring patient safety by using color-coded wristbands are a common practice, the lack of standardization may pose an unknown hazard. Elsewhere in this journal, we present findings from a survey reinforcing the need for standardization around this issue.

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REFERENCE

1. Hayes S. Wristbands called patient safety risk. *St. Petersburg Times* 10 Dec 2004. p 1A.