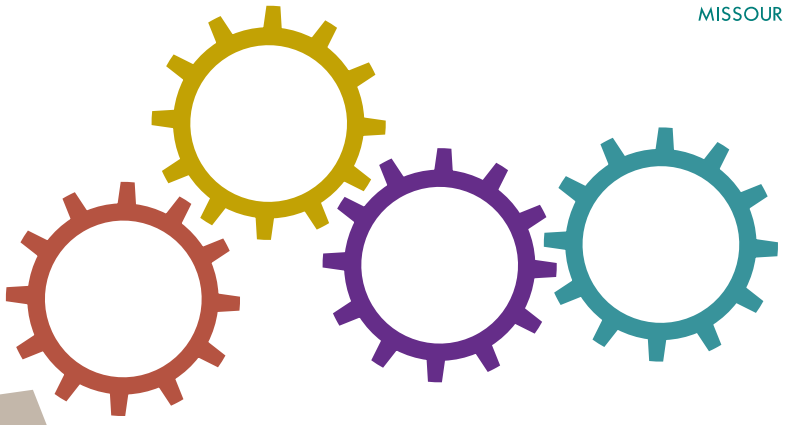
MHA
MISSOURI HOSPITAL ASSOCIATION



STANDARDIZED, PLAIN LANGUAGE EMERGENCY CODES

Implementation Guide

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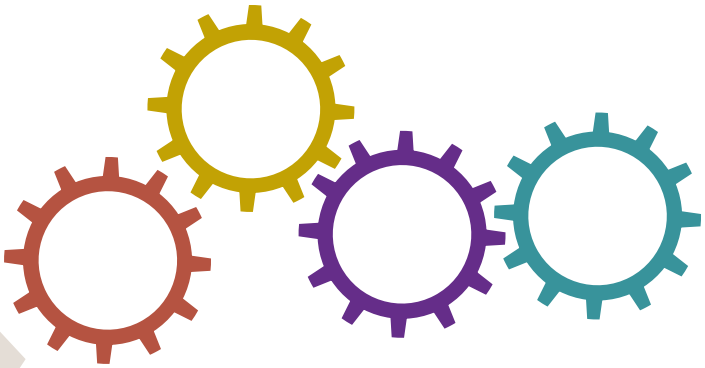


Dear Missouri Hospital Chief Executive Officers:

As president and CEO of the Missouri Hospital Association, I am pleased that the MHA Board of Trustees endorses the adoption of standardized, plain language emergency codes throughout Missouri hospitals and facilities. The use of standardized codes will increase transparency, reduce patient errors using a simple and practical approach and promote the safety of patients, hospital employees and visitors. The standardized codes were developed by a workgroup of 30 hospitals and the recommendation of the MHA Emergency Preparedness Advisory Committee.

The decision to adopt standardized codes followed the requests of many Missouri hospitals. In 2012, MHA conducted a survey and found significant variation among hospitals, including nine different emergency codes that were used to notify staff of a hospital evacuation. Even in specific geographic regions and metropolitan areas, the variation was significant.

Each hospital will need to review the endorsed codes and determine which are most appropriate for adoption. Although the initiative is voluntary, you are encouraged to consider adoption of all standardized codes. MHA has provided an implementation guide to assist hospitals with this transition. The goal is to have all Missouri hospitals using these standardized, plain language emergency codes by **Jan. 1, 2014.**

Sincerely,

Herb B. Kuhn
MHA President and CEO

Executive Summary

BACKGROUND

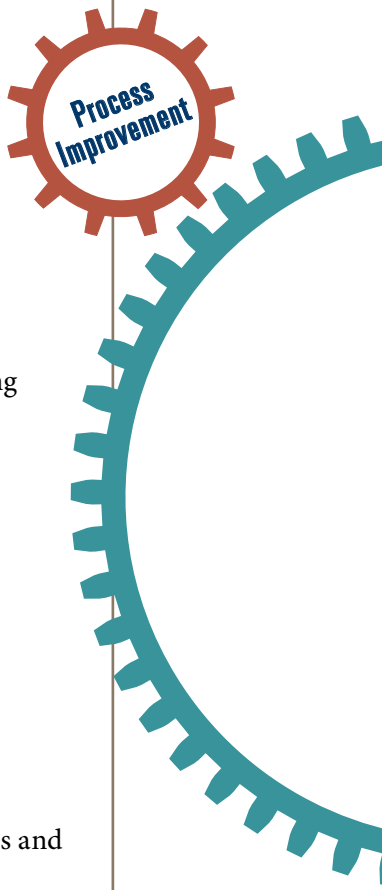
In mid-2011, the Missouri Hospital Association began receiving requests from its members to lead an initiative to standardize the emergency codes used in Missouri hospitals. The requests came from all areas of the state and from health systems, as well as small, rural hospitals.

This follows a national trend to standardize emergency codes as recommended by the Joint Commission in 2012. Further, there is a trend to adopt plain language versus color code announcements. The adoption of plain language is supported by the following organizations or reports.

- U.S. Department of Health and Human Services
- U.S. Department of Homeland Security
- The National Incident Management System (2008)
- The Institute of Medicine's Health Literacy report and recommendations (2004)

There is no one definition for plain language, but two criteria are generally recognized.

- People understand the information received without further extensive explanation.
- People know what actions are required based on the information received.



MHA 2012 HOSPITAL ASSESSMENT

Based on these requests, MHA surveyed hospitals about their current code nomenclature and invited participation in a workgroup. Among the 134 hospitals that responded to the survey, representatives from 30 hospitals agreed to serve on the workgroup, and the following information was identified.

- Four different codes were used to announce a fire.
- Seven different codes were used to announce a medical emergency.
- Six different codes were used to announce an abduction of an infant, child or adult.
- Seven different codes were used to announce a severe weather alert.
- Nine different codes were used to announce a mass casualty event.
- Seven different codes were used to announce a hazardous spill.
- Nine different codes were used to announce a hospital evacuation.
- Ten different codes were used to announce a security threat.

The workgroup has been meeting since July 2012 and has established the following objectives and principles.

OBJECTIVES FOR THE STANDARDIZED EMERGENCY CODE WORKGROUP

- Reduce variation of emergency codes among Missouri hospitals.
- Increase competency-based skills of hospital staff working in multiple facilities.
- Increase staff, patient and public safety within hospitals and campuses.
- Promote transparency of safety protocols.
- Align, if possible, standardized codes with neighboring states.

PRINCIPLES FOR ADOPTING STANDARDIZED EMERGENCY CODES

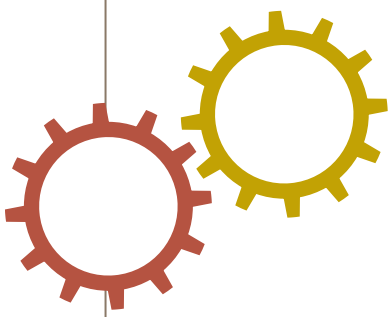
The following principles were developed to guide the development of the initiative.

- This is a voluntary initiative; it is not a mandate to adopt all or any of the recommended emergency codes.
- The recommendations are based on scholarly literature and national safety recommendations.
- Use of plain language emergency codes is the long-term goal of this initiative to ensure transparency and patient and public safety.
- Minimizing overhead pages in hospitals is encouraged to provide a quieter hospital environment, leading to improved safety and patient outcomes.

IMPLEMENTATION STRATEGY

This voluntary initiative is intended to improve patient and public safety and is not a prescriptive mandate; hospitals are not mandated to adopt all or any of the emergency codes. The implementation will be phased in during a one-year time frame. Several hospitals participating in the workgroup have begun using the recommended emergency codes.

MHA will provide resources and guidance to hospitals. Each hospital will need to review these recommendations with their emergency preparedness committees and hospital leadership and governance. It is important that each hospital carefully consider each emergency code as a separate issue. It is encouraged, but not required, that a hospital adopt the recommendations for all emergency codes.



STANDARDIZED, PLAIN LANGUAGE EMERGENCY CODE RECOMMENDATION

Missouri hospitals are committed to ensuring patient and public safety within each hospital facility. The recommendation to adopt standardized emergency codes has been developed by experts from hospitals across Missouri and is based on scholarly literature, research and national guidelines.

Missouri hospitals are encouraged to adopt the following standardized, plain language codes to further protect patient and public safety within hospitals and health care facilities. This transition should be completed by Jan. 1, 2014.

FACILITY ALERT

Event	Recommended Plain Language	Alternate Code
Evacuation	"Facility Alert + Evacuation + Descriptor (location)"	None
Fire	"Code Red + Descriptor (location)"	Plain Language
Hazardous Spill	"Facility Alert + Hazardous Spill + Descriptor (location)"	Code Orange

WEATHER ALERT

Event	Recommended Plain Language	Alternate Code
Severe Weather	"Weather Alert + Descriptor (threat/location) + Instruction"	None

SECURITY ALERT

Event	Recommended Plain Language	Alternate Code
Abduction	"Security Alert + Descriptor (threat/location)"	Code Pink
Missing Person	"Security Alert + Descriptor"	None
Armed Violent Intruder/Active Shooter/Hostage	"Security Alert + Descriptor (threat/location)"	Code Silver
Bomb Threat	"Security Alert + Descriptor (threat/location)"	Code Black
Combative Patient/ Person	"Security Alert + Security Assistance Requested + (location)"	None

MEDICAL ALERT

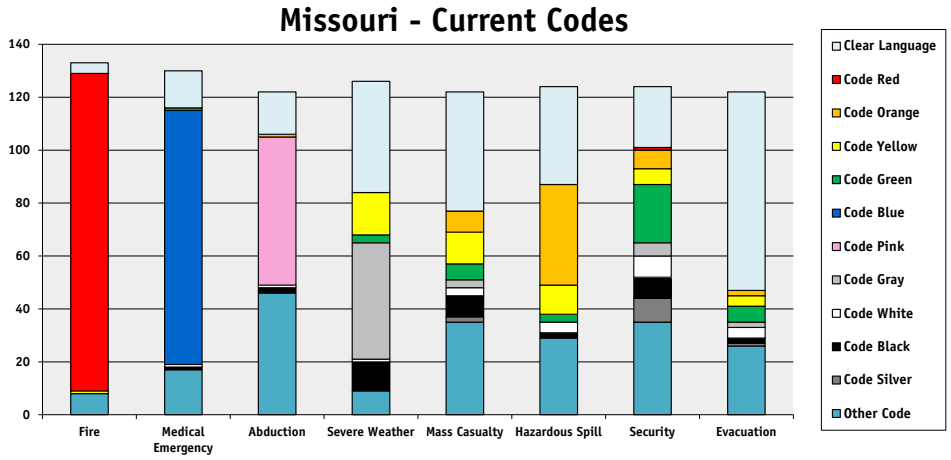
Event	Recommended Plain Language	Alternate Code
Mass Casualty	"Medical Alert + Mass Casualty + Descriptor"	None
Medical Decontamination	"Medical Alert + Medical Decontamination + Descriptor"	None
Medical Emergency	"Code Blue + Descriptor (location)"	Plain Language

Note: Because of the widely accepted use of the two color codes for fire and medical emergency, the workgroup determined it appropriate to maintain these two color codes as the primary recommendation, with plain language as the secondary recommendation.

Recommendation

BACKGROUND

In mid-2011, MHA received several member requests to lead an initiative to standardize the emergency codes used to notify staff, patients and visitors. Examples include the emergency codes used to announce a fire, abduction, medical emergency or an armed violent intruder. Based on these requests, in January 2012, MHA included survey questions about current emergency codes in its annual emergency preparedness capacity assessment survey. The results provided evidence of significant variability across the state and even within geographic regions. The following graph illustrates that variability (see Appendix C for the full survey results).



Source: 2012 MHA Member Hospitals Annual Emergency Preparedness Capacity Assessment
n = 134 hospitals

MHA staff convened a workgroup representing 30 hospitals of all sizes across Missouri to study national literature, including other state programs, to develop a recommendation for standardized emergency codes (see Appendix B for the committee roster). This group provided considerable time and expertise to ensure full consideration of this initiative, including the resources required for implementation. The following recommendation was developed by the MHA Standardized Emergency Code Workgroup, with input from the MHA Emergency Preparedness Advisory Committee.

Coordination

GOALS

The goals of this initiative are to:

- reduce variation of emergency codes among Missouri hospitals
- increase competency-based skills of hospital staff working in multiple facilities
- increase staff, patient and public safety within hospitals and campuses
- promote transparency of safety protocols
- align, if possible, standardized codes with neighboring states

PRINCIPLES FOR ADOPTING STANDARDIZED, PLAIN LANGUAGE EMERGENCY CODES

The following principles were developed to guide the development of the initiative.

- This is a voluntary initiative; it is not a mandate to adopt all or any of the emergency codes recommended.
- The recommendations are based on scholarly literature and national safety recommendations.
- Use of plain language emergency codes is the long-term goal of this initiative to ensure transparency and patient and public safety.
- Minimizing overhead pages in hospitals is encouraged to provide a quieter hospital environment, leading to improved safety and patient outcomes.

IMPLEMENTATION TIME LINE

It is the recommendation of the workgroup that all participating hospitals adopt the standardized codes by January 2014. The following implementation time line was developed to support hospitals throughout 2013.

APRIL 2013: *announce new initiative and recommendation*

APRIL 2013: *provide hospitals resources to support implementation*

MAY 2013: *conduct webinars to provide additional education and answer questions*

JUNE 2013: *seek hospitals' intent to adopt specific codes and date of adoption*

AUGUST 2013: *conduct webinars to provide updates and answer questions; share implementation strategies among participating hospitals*

JANUARY 2014: *standardized emergency codes among participating hospitals adopted*

JUNE 2014: *evaluate implementation status*

RATIONALE FOR PLAIN LANGUAGE EMERGENCY CODES

In an era of increased transparency, there are several national initiatives to promote plain language among many disciplines, including health care providers and emergency managers. Plain language is a central tenet of health literacy and has been adopted to demonstrate improved patient safety outcomes (Institute of Medicine, 2004).

Staff who are new or work at multiple hospitals may not recall unique code nomenclature, resulting in an adverse action. For example, based on the 2012 MHA survey, there are nine different code colors or names currently used for both mass casualty and security alerts. Even regional variation is significant, as evidenced by nine codes for security in one Missouri region (see Appendix C).

There is no one universal definition for plain language, but current adoption follows these two criteria (Redish, 2000; U.S. Health and Human Services, n.d.).

- People understand the information received without further extensive explanation.
- People know what actions are required based on the information received.

The recommendation to use plain language also is evident in the field of emergency preparedness. The use of "10" codes such as "10-40" are no longer recommended or used among law enforcement and public safety officials. The National Incident Management System has established the following plain language requirements for communication and information management (U.S. Department of Homeland Security, 2008, pg. 29).

"The ability of emergency management/response personnel from different disciplines, jurisdictions, organizations and agencies to work together depends greatly on their ability to communicate with each other. Common terminology enables emergency management/response personnel to communicate clearly with one another and effectively coordinate activities, no matter the size, scope, location or complexity of the incident."

"The use of plain language (clear text) in emergency management and incident response is a matter of public safety, especially the safety of emergency management/response personnel and those affected by the incident. It is critical that all those involved with an incident know and use commonly established operational structures, terminology, policies and procedures. This will facilitate interoperability across agencies/organizations, jurisdictions and disciplines."

The NIMS guidance provides the framework for health care preparedness and response, including the use of the incident command system.

Adoption of standardized, plain language also is an emerging trend among other states. Several states have adopted standardized codes during the past few years, and nearly all have included recommendations for plain language codes, including Kansas.

STANDARDIZED, PLAIN LANGUAGE EMERGENCY CODE RECOMMENDATION

Missouri hospitals are committed to ensuring patient and public safety within each hospital facility. The recommendation to adopt standardized emergency codes has been developed by experts from hospitals across Missouri and is based on scholarly literature, research and national guidelines.

Missouri hospitals are encouraged to adopt the following standardized, plain language codes to further protect patient and public safety within hospitals and health care facilities. This transition should be completed by Jan. 1, 2014.

FACILITY ALERT

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WEATHER ALERT

Event	Recommended Plain Language	Alternate Code
Severe Weather	"Weather Alert + Descriptor (threat/location) + Instruction"	None

SECURITY ALERT

Event	Recommended Plain Language	Alternate Code
Abduction	"Security Alert + Descriptor (threat/location)"	Code Pink
Missing Person	"Security Alert + Descriptor"	None
Armed Violent Intruder/Active Shooter/Hostage	"Security Alert + Descriptor (threat/location)"	Code Silver
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MEDICAL ALERT

Event	Recommended Plain Language	Alternate Code
Mass Casualty	"Medical Alert + Mass Casualty + Descriptor"	None
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Medical Emergency	"Code Blue + Descriptor (location)"	Plain Language

Note: Because of the widely accepted use of the two color codes for fire and medical emergency, the workgroup determined it appropriate to maintain these two color codes as the primary recommendation, with plain language as the secondary recommendation.

Emergency Code Notification

OVERHEAD PAGING VERSUS SILENT NOTIFICATION

In 2001, the Institute of Medicine issued a report, "Quality Chasm," identifying six aims of patient quality and safety: safe, timely, effective, efficient, equitable and patient-centered. This landmark report has served as the foundation for many national initiatives to improve patient safety and clinical outcomes.

Excessive noise in a hospital setting has been attributed to negative clinical outcomes. Research suggests that "Hospital noise has been associated with patient risk for sleep disturbance, cardiovascular response, increased length of stay, increased incidence of re-hospitalization and other problems" (Ryherd, Okcu, Ackerman, Zimring and Persson, 2011, pg. 491).

A study by the University of Virginia Health System identified noise as the most important irritant to surgical patients (Moore, Nguyen, Nolan, Robinson, Ryals, Imbrie & Spotnitz, 1998). This study and others led to the inclusion of noise as core measures for patient satisfaction in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) reported on the U.S. Department of Health and Human Services' website, Hospital Compare. The measure captures the percentage of patients who report "that the area around their room was always quiet at night" (Hospital Compare, n.d.).

Further, research also suggests excessive noise may contribute to the overall stress, job performance and job satisfaction among hospital staff (Ryherd, 2011). Noise must be considered as a contributing factor in patient outcomes and perhaps staff performance and stress, as well.

However, when assessing the use of overhead paging versus call notification processes, it is important to reference the National Fire Protection Association's Life Safety Code 101 to ensure compliance with alarm annunciation (2012).

Based on this premise, the committee recommends the following considerations when determining methods of emergency code notification.

Overhead paging likely is appropriate when:

- the situation requires all or many building occupants hear the notice
- the situation requires additional or follow-up information to all or many building occupants
- the situation requires an immediate response from all staff
- recommended based on the NFPA Life Safety Code compliance

Call notification or mass texting to identified groups of staff likely is appropriate when:

- the overall goal is to reduce excessive noise within the hospital
- the situation requires specific staff have immediate notice for response
- the patient population may be considered easily excitable, such as behavioral patients

Many hospitals use established call notification systems. For those that do not, Missouri hospitals have access to a hospital-based call notification system through the EMResource™ — Hospital Incident Command System. This system may be set up to send emergency notifications to all or select hospital staff. This system also establishes notification of area hospitals' emergency preparedness personnel to expedite communication and coordination for emergencies requiring regional response.

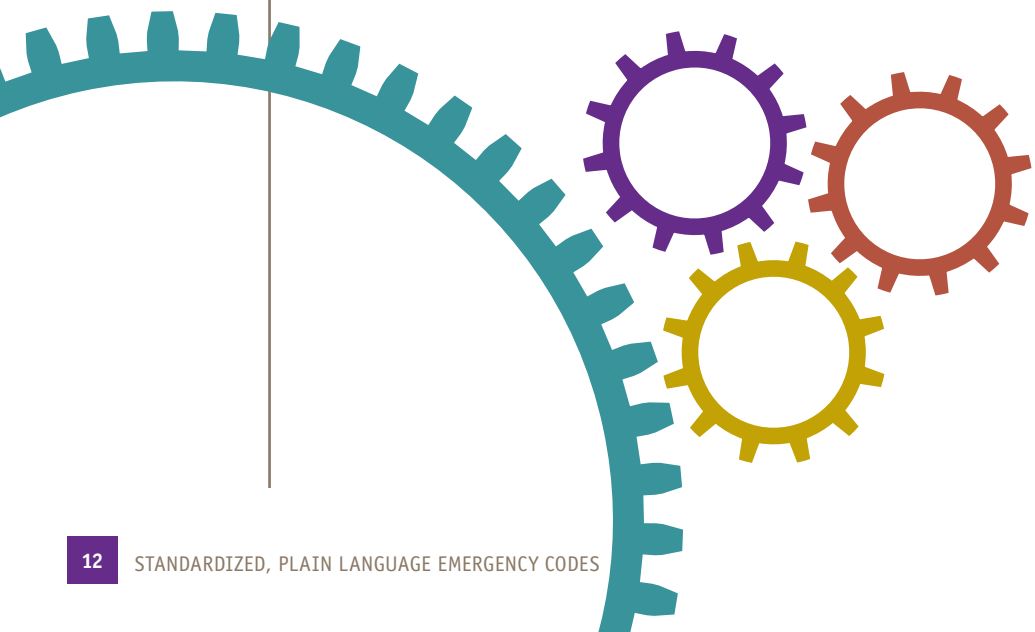
Implementation Strategy

IMPLEMENTATION STRATEGY

This voluntary initiative is intended to improve patient and public safety; it is not a prescriptive mandate. Resources provided in this toolkit provide implementation ideas and guidance. Hospitals will need to review these recommendations with their emergency preparedness committees, hospital leadership and governance. It is important each hospital carefully consider each emergency code as a separate issue. It is encouraged, but not required, that a hospital adopt all standardized codes.

The toolkit provides information, policy templates and educational materials to assist hospitals. However, hospitals may need to develop additional materials for their specific badging or card systems.

It is recommended hospitals follow these steps to implement standardized, plain language codes once the hospital has established formal organizational approval and decision to adopt the codes. The steps and time lines are guidance only and should be modified to meet organizational priorities and approaches.



ACTION STEPS

Nine Months Before Implementation: AWARENESS

- Draft a letter from the CEO or governance board and disseminate widely among hospital employees and key external stakeholders.
- Include an announcement in the employee newsletter.
- Recognize any employees or committees willing to help implement the plain language codes.
- Announce a "go-live" date.

Eight Months Before Implementation: ESTABLISH COMMITTEES

- Authorize a committee to review and update all policies.
- Authorize a committee to review and update all hospital materials.
- Authorize a committee or individuals to update the hospital emergency operations plan.
- Authorize a committee or individuals to update all code cards, flip charts, posters or other emergency management tools.
- Authorize a committee or individuals to update all telecommunication scripts, algorithms and materials.
- Develop a formal education plan for all employees.
- Identify train-the-trainers to serve as educators and champions, announce the trainers' names to hospital employees and schedule the trainer training.
- Establish and promote mechanisms for broad-based, frequent organizational communication, which may include the following.
  - periodic staff emails
  - periodic newsletter articles providing updates and progress
  - posters, flyers or other materials that include the "go-live" date

Seven Months Before Implementation: TRAINING PLAN

- Conduct train-the-trainer competency-based training.
- Finalize education plan.
- Develop draft education materials; do not mass produce.
- Provide update to hospital governance board, leadership team and key external stakeholders.

Six Months Before Implementation: FINALIZE POLICY AND TRAINING

- Begin pilot testing hospital employee training.
- Revise training plan and materials based on pilot testing.
- Schedule organizationwide training sessions.
- Finalize and produce education materials.
- Finalize policies.

Five Months Before Implementation: TRAINING AND POLICY DISSEMINATION

- Begin organizationwide training.
- Disseminate all materials to each hospital department.
- Disseminate all revised policies.
- Begin to disseminate posters, flyers and other awareness materials.
- Consider a challenge between hospital departments to complete training requirements.

Four Months Before Implementation: UPDATES

- Provide an update in the employee newsletter on the progress, include the "go-live" date.
- Continue with competency-based education.
- Continue to disseminate posters, flyers and other awareness materials.
- Update hospital governance and key external stakeholders as appropriate.

Three Months Before Implementation: REINFORCEMENT

- Continue organizationwide training.
- Continue communication through posters, newsletters, staff meetings and other forums as appropriate.

Two Months Before Implementation: FINALIZE

- Complete organization-wide training.
- Continue communication through posters, newsletters, staff meetings and other forums as appropriate.
- Ensure updated policies are available for all hospital employees.
- Ensure the emergency operations plan has been updated and formally adopted.
- Ensure all emergency management tools and resources have been updated.
- Ensure all telecommunication scripts, algorithms and materials have been updated.
- Ensure public safety partners (fire, police, EMS) are aware of the new policies, codes and "go-live" date.

One Month Before Implementation: PREPARE FOR "GO-LIVE" DATE

- Begin a daily or weekly countdown until the "go-live" date.
- Develop a mechanism to ensure clarification of any questions.
- Ensure all department managers are ready to implement the new codes.
- Provide broad communitywide articles to educate the public on this change.
- Display awareness materials with the "go-live" date throughout the organization.
- Ensure trainers are available to answer questions.
- Communicate readiness to hospital governance and leadership team.
- Recognize employees and committees for their work to ensure a successful implementation.

IMPLEMENTATION

One Month Post Implementation: INITIAL EVALUATION

- Congratulate and recognize employees and committees for leading a successful implementation.
- Congratulate and recognize all employees for a successful implementation.
- Assess adoption of plain language codes in staff meetings, education sessions and leadership team meetings.
- Conduct department drills to assess adoption during the first five months.

Six Months Post Implementation: EVALUATION

- Conduct an organizationwide drill to assess adoption six months post-implementation.

FACILITY ALERTS

Purpose: Provide for the safety and security of patients, employees and visitors at all times, including the management of essential utilities.

TYPES OF FACILITY THREATS

- Evacuation
- Fire
- Hazardous spill (does not include mass patient decontamination alert)

FACILITY UTILITIES

- Electrical power
- Water
- Fuel
- Medical gasses, ventilation and vacuum systems

NATIONAL RECOMMENDATIONS FOR POLICIES AND PROTOCOLS

The Joint Commission

The Joint Commission includes the management of safety, security and utilities as two of the six critical functions of an emergency operations plan. Specifically, the Joint Commission includes the following as elements of performance (Joint Commission Resources, 2012, pgs. 104, 145, 158).

How the organization will:

- manage hazardous materials and waste
- control the entrance into and out of the facility during an incident
- control individual movement within the facility during an incident
- control vehicular access to the facility during an incident
- manage a utility failure caused by an interruption of services
- establish back-up systems for critical utilities
- provide alternate sources and methods of providing:
  - electricity
  - potable water
  - nonpotable water
  - fuel
  - medical gasses and vacuum systems
- manage the personal hygiene and sanitation of patients

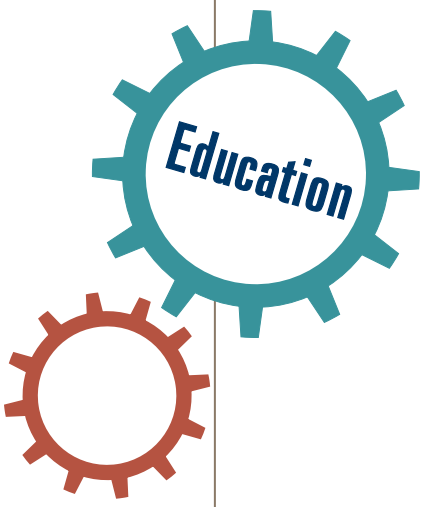
National Fire Protection Association

The National Fire Protection Association's Life Safety Code 101 provides detailed codes and recommendations about fire prevention, protection and alarm annunciation.

SUPPORTING INFORMATION AND REFERENCES

Joint Commission Resources (2012). Emergency management in health care: an all hazards approach (2nd ed). ISBN: 978-1-59940-701-2.

National Fire Protection Association (2012) Life Safety Code 101. Retrieved March 15, 2013, from *http://www.nfpa.org/aboutthecodes/aboutthecodes.asp?docnum=101.*



WEATHER ALERTS

Purpose: Provide clear, plain language instructions and situational awareness to hospital employees, patients and visitors.

GLOSSARY OF WEATHER-RELATED EVENTS, CITED DIRECTLY FROM THE NATIONAL WEATHER SERVICE

Flash Flood — A rapid and extreme flow of high water rushing into a normally dry area, or a rapid water level rise in a stream or creek above a predetermined flood level that begins within six hours of the causative event (e.g., intense rainfall, dam failure, ice jam). However, the actual time threshold may vary in different parts of the country. Ongoing flooding can intensify to flash flooding in cases where intense rainfall results in a rapid surge of rising flood waters.

Flood Watch — Issued to inform the public and cooperating agencies that current and developing hydrometeorological conditions are such that there is a threat of flooding, but the occurrence is neither certain nor imminent.

Flood Warning — (FLW) In hydrologic terms, a release by the NWS to inform the public of flooding along larger streams in which there is a serious threat to life or property. A flood warning will usually contain river stage (level) forecasts.

Heat Advisory — Issued within 12 hours of the onset of the following conditions: heat index of at least 105°F but less than 115°F for less than three hours per day or nighttime lows above 80°F for two consecutive days.

Severe Thunderstorm — A thunderstorm that produces a tornado, winds of at least 58 mph (50 knots), and/or hail at least 1 inch in diameter. Structural wind damage may imply the occurrence of a severe thunderstorm. A thunderstorm wind equal to or greater than 40 mph (35 knots) and/or hail of at least 1 inch is defined as approaching severe.

Tornado Watch — This is issued by the National Weather Service when conditions are favorable for the development of tornadoes in and close to the watch area. Their size can vary depending on the weather situation. They are usually issued for duration of four to eight hours. They normally are issued well in advance of the actual occurrence of severe weather. During the watch, people should review tornado safety rules and be prepared to move to a place of safety if threatening weather approaches.

A tornado watch is issued by the Storm Prediction Center (SPC) in Norman, Okla. Before the issuance of a tornado watch, SPC will usually contact the affected local National Weather Forecast Office (NWFO), and they will discuss what their current thinking is on the weather situation. Afterwards, SPC will issue a preliminary tornado watch, and then the affected NWFO will then adjust the watch (adding or eliminating counties/parishes) and then issue it to the public. After

adjusting the watch, the NWFO will let the public know which counties are included by way of a Watch Redefining Statement. During the watch, the NWFO will keep the public informed on what is happening in the watch area and also let the public know when the watch has expired or been canceled.

Tornado Warning — This is issued when a tornado is indicated by the WSR-88D radar or sighted by spotters; therefore, people in the affected area should seek safe shelter immediately. They can be issued without a tornado watch being already in effect. They are usually issued for a duration of around 30 minutes.

A tornado warning is issued by your local NWFO. It will include where the tornado was located and what towns will be in its path. If the thunderstorm that is causing the tornado also is producing torrential rains, this warning also may be combined with a flash flood warning.

After it has been issued, the affected NWFO will be followed periodically with severe weather statements. These statements will contain updated information on the tornado, and they also will let the public know when the warning is no longer in effect.

Wind Chill Factor — Increased wind speeds accelerate heat loss from exposed skin, and the wind chill is a measure of this effect. No specific rules exist for determining when wind chill becomes dangerous. As a general rule, the threshold for potentially dangerous wind chill conditions is about -20°F.

Winter Weather Advisory — This product is issued by the National Weather Service when a low pressure system produces a combination of winter weather (snow, freezing rain, sleet, etc.) that presents a hazard but does not meet warning criteria.

Blizzard — A blizzard means that the following conditions are expected to prevail for a period of three hours or longer: sustained wind or frequent gusts to 35 miles an hour or greater and a considerable falling and/or blowing snow (i.e., reducing visibility frequently to less than a quarter of a mile).

REFERENCE

National Oceanic and Atmospheric Administration, National Weather Service. (n.d.) Retrieved February 8, 2013, from *www.weather.gov.*

SECURITY ALERT

Purpose: To protect employees, patients and visitors from any situation or person posing a threat to the safety of any individual(s) within the hospital.

TYPES

- Abduction (all ages)
- Missing person (all ages)
- Armed violent intruder, active shooter, hostage
- Bomb threat
- Combative person/patient

NATIONAL RECOMMENDATIONS FOR POLICIES AND PROTOCOLS

The National Center for Missing and Exploited Children

The National Center for Missing and Exploited Children offers a free online book and self-assessment form for health care organizations. The book and assessment include recommended actions to prevent an infant abduction and what to do when an abduction occurs. The resources can be found at *www.ncmec.org/missingkids/servlet/ResourceServlet?LanguageCountry=en_US&PageId=468*.

The PDFs are available directly at *www.ncmec.org/en_US/publications/NC05.pdf* and *www.ncmec.org/en_US/publications/NC05assessment.pdf*.

The Joint Commission

The Joint Commission includes the management of safety, security and utilities as two of the six critical functions of an emergency operations plan. Specifically, the Joint Commission includes the following as elements of performance (Joint Commission Resources, 2012, pg. 104-105).

How the organization will:

- arrange internal security
- establish roles and coordinate with community public safety and security agencies
- establish emergency security planning, which includes:
  - individual movement within the facility, including elevators and stairwells
  - access in and out of the facility
  - vehicular movement on the facility grounds
  - uninterrupted access for ambulances and other response vehicles
  - authorized access for first responders and emergency personnel

Missouri Hospital Association

The Missouri Hospital Association has policy templates for armed violent intruder response and recommendations for sudden onset incident command action steps.

REFERENCES:

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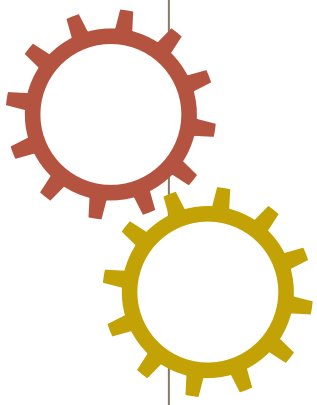
Mitigation Dynamics, Inc. (2012). Sample policy templates. Available at *www.mhanet.com*.

National Center for Missing and Exploited Children (n.d). Retrieved February 8, 2013, from *www.missingkids.com*.



MEDICAL ALERTS

Purpose: To provide medical care and support to patients and incident victims while maintaining care and safety of patients, employees and visitors within a health care facility during an incident.

TYPES

- Mass casualty
- Medical emergency
- Chemical or radiological decontamination

NATIONAL RECOMMENDATIONS FOR POLICIES AND PROTOCOLS

The Joint Commission

The Joint Commission includes the management of clinical care and safety as one of the six critical functions of an emergency operations plan. Specifically, the Joint Commission includes the following as elements of performance (Joint Commission Resources, 2012, pgs. 104, 158).

How the organization will :

- provide for radiological, biological and chemical isolation and decontamination
- manage patient triage, assessment, treatment, transfer, admission, discharge and scheduling
- manage horizontal and vertical patient evacuation
- manage increased demand for clinical services
- manage increased demand for mental health services
- manage mortuary services
- track patients location and clinical information

SUPPORTING INFORMATION AND REFERENCES

Joint Commission Resources (2012). Emergency management in health care: an all hazards approach (2nd ed). ISBN: 978-1-59940-701-2.

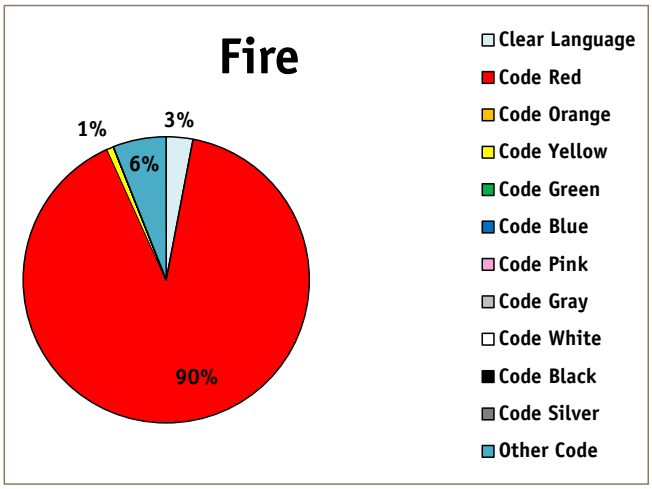
APPENDIX A: MHA STANDARDIZED CODE WORKGROUP MEMBERS

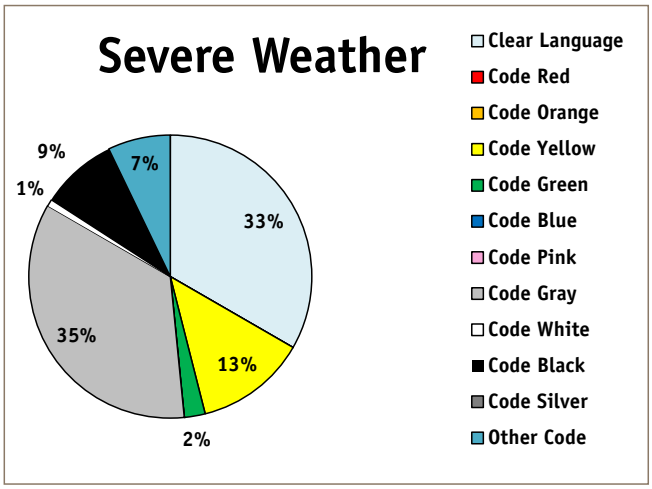
Name	Title	Organization
Andrew Atkinson	Regional Quality Improvement Officer	Missouri Department of Mental Health
Michael Behringer, RRT	Emergency Preparedness Coordinator	Bates County Memorial Hospital
Debbie Blinzler, R.N., BSN	Education Coordinator	Cox Monett
April Burchett	Administration Department Secretary	Cedar County Memorial Hospital
Jo Ann Cantriel, R.N., BSN	Education Manager	Capital Region Medical Center
Joy Cauthorn, R.N., BSN, CIC	Infection Control Nurse	Missouri Delta Medical Center
Derek Collins	Emergency Preparedness Coordinator	Saint Luke's Health System
Russ Conroy, RRT, MBA	Emergency Preparedness Coordinator	Mercy Hospital Springfield
Christie A. DeArman, R.N.	Compliance Officer/Education Director	Southeast Health Center of Stoddard County
Spencer Dobbs	Safety Officer	Mercy Hospital Joplin
Rhonda Dorrell, R.N.	Director of Emergency Services	Audrain Medical Center
Steve Fine	Network Coordinator Emergency Management	SSM DePaul Health Center
Jenni Fleming	Director of Security/Emergency Preparedness Coordinator	Cass Regional Medical Center
Miranda Floyd, R.N., BSN	Chief Nursing Officer	Northwest Medical Center
Robert J. Grayhek, R.N., BSN	Director, Trauma and Disaster Services	Saint Francis Medical Center
Debbie Halinar, R.N.	Director, Infection Control/Safety	Phelps County Regional Medical Center
Frank Hayden	Director, Ancillary Services	Hedrick Medical Center
Jason Henry, R.N., CEN, EMT	Emergency Management Officer (Corporate)	Cox South
Damon C. Longworth	Chief Financial Officer	Missouri Department of Mental Health CPS - Southeast Region
Linda S. Maly, R.N., BSN, LNHA	Safety Officer	St. Luke's Hospital
Beverly Morris, R.N.	Emergency Department Nurse Manager	Cox Monett
Gary Douglas Ruble, CPE, CPMM, RHSO	Vice President, Facilities	Hannibal Regional Healthcare System
Lou Smith	Risk/Safety Manager	Cox Medical Center Branson
Matthew C. Soule	Safety Director	Children's Mercy Hospitals and Clinics
Jeffery J. Stackle	Emergency Preparedness Coordinator	Madison Medical Center
Leslie Sutton, R.N.	Director of Quality Management	Landmark Hospital of Columbia
Carolyn S. Wells, R.N.	Director, Trauma Services	Liberty Hospital
Eamonn Wheelock	Safety & Emergency Preparedness Coordinator	University Hospital and Clinics
Steve Williams, CHSP	Senior Director Corporate Support Services Safety Compliance	Truman Medical Centers Inc.
Karen Wilson, R.N.	Emergency Room Director/Disaster Management	Mercy Hospital Aurora
Sarah Yelton	Quality Resource Analyst	Saint Luke's Hospital of Kansas City

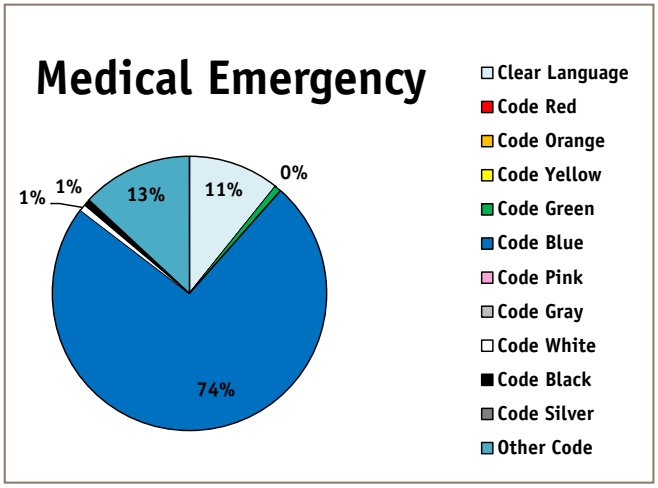
APPENDIX B: MHA EMERGENCY PREPAREDNESS ADVISORY COMMITTEE MEMBERS

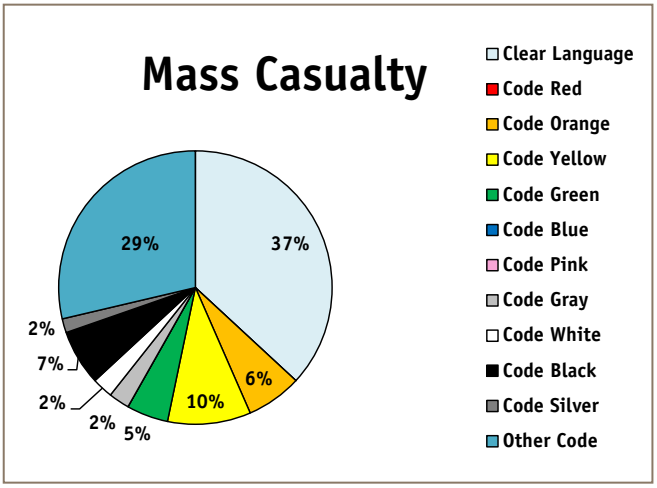
Name	Title	Organization
Andrew Atkinson	Regional Quality Improvement Officer	Missouri Department of Mental Health
Linda G. Brown, MSN, R.N., APRN, BC, FNP-C	Director, Emergency Services	SoutheastHEALTH
Stephanie Browning	Director	Columbia/Boone County Health Department
Rita M. Brumfield, R.N., MSN	Chief Nursing Officer	Ste. Genevieve County Memorial Hospital
Russ Conroy, RRT, MBA	Emergency Preparedness Coordinator	Mercy Hospital Springfield
Melissa Friel	Director	Missouri Department of Health and Senior Services
Jerry Glotzer	Director, Environmental Health/Safety	Barnes-Jewish Hospital
Josephine E. Goode Evans	Corporate V.P., Risk Services	SSM Health Care
Kathy Hadlock, R.N., BSN	Healthcare Systems Preparedness Program Manager	Missouri DHSS, Center for Emergency Response and Terrorism
Jason Henry, R.N., CEN, EMT	Emergency Management Officer (Corporate)	Cox South
Sonia Jordan	MRC Region 7 Regional Coordinator	Office of the Civilian Volunteer Medical Reserve Corps
Kimberly S. Lowe, LPN	Manager, Patient Safety/PI	Mercy St. Francis Hospital
Dan Manley, EMT-P	Emergency Services Planner	Mid-America Regional Council
Dennis G. Manley, R.N., BSN, HRM, CPHQ	Vice President of Quality, Interim Chief Nursing Officer	Mercy Hospital Joplin
Amy J. Michael	Chief Operating Officer	Sullivan County Memorial Hospital
Wallace N. Patrick, R.N.	Emergency Management Coordinator	Heartland Regional Medical Center
Robert Patterson	Director, Emergency Medical Services	Mercy Hospital Springfield
Chris Pickering	Homeland Security Coordinator	Missouri Office of Homeland Security, Department of Public Safety
Janice Pirner, CPHQ, LPN	Member Services Manager	Missouri Primary Care Association
Leslie L. Porth, R.N., MPH	Vice President of Health Planning	Missouri Hospital Association
Vanessa Poston	Environmental Health & Safety Manager	Missouri Baptist Medical Center
Gary Douglas Ruble, CPE, CPMM, RHSO	Vice President, Facilities	Hannibal Regional Healthcare System
George Salsman	Network Director, Emergency Preparedness/ Safety	SSM Health Care - St. Louis
Helen Sandkuhl, R.N., MSN, FAEN	Nursing Director of Emergency Services	Saint Louis University Hospital
David Schemenauer	Director, Safety, Security and Emergency Preparedness	Saint Luke's Health System
Chris A. Smith, MHA, MEP	Manager, Communications and Emergency Preparedness	University Hospital and Clinics
Matthew C. Soule	Director, Safety	Children's Mercy Hospitals and Clinics
G. Mark Thorp	Fire Chief	Clayton Fire Department
Julie Weber, BS Pharm, CSPI	Director, MO Poison Center	SSM Cardinal Glennon Children's Medical Center
Janet Weckenborg, BSN, MHA, FACHE	Vice President, Operations	Capital Region Medical Center
Carolyn S. Wells, R.N.	Director, Trauma Services	Liberty Hospital
John H Whitaker	Public Safety Administrator	St. Louis Area Regional Response System
Jenny Wiley	Coordinator, Disaster Readiness	Missouri Department of Mental Health
Joseph V. Yust	Facilities Director	Freeman Neosho Hospital

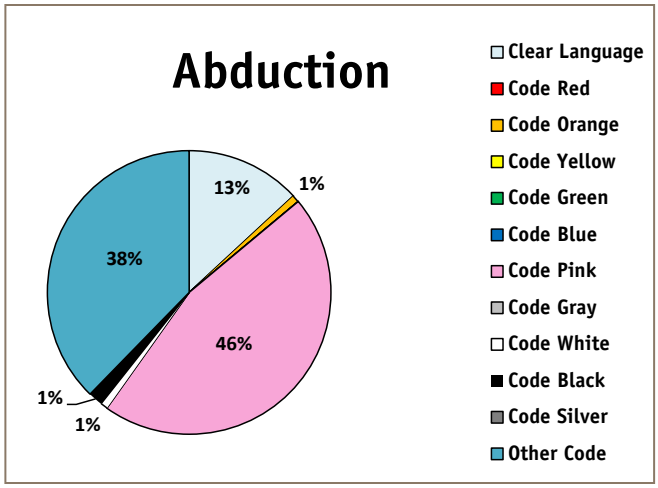
APPENDIX C: 2012 MHA ANNUAL EMERGENCY PREPAREDNESS SURVEY: CURRENT EMERGENCY CODES — n = 134 HOSPITALS

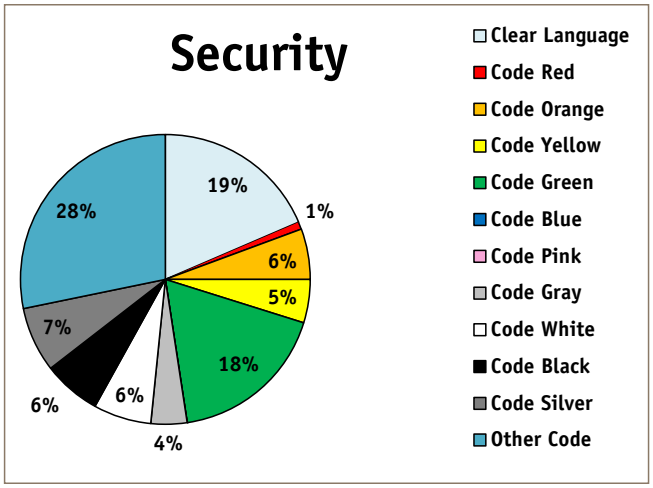


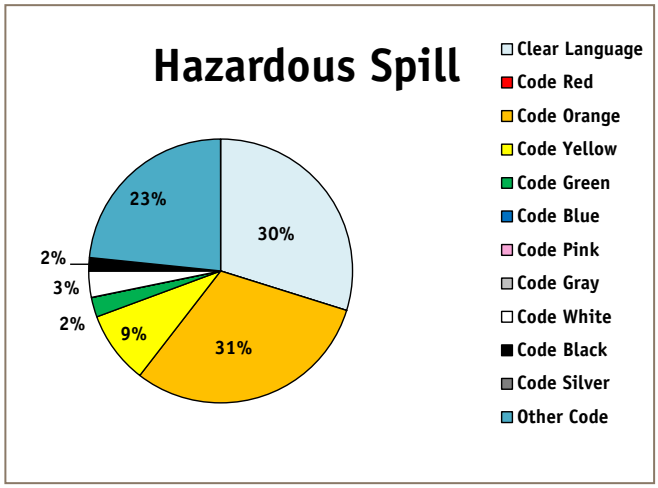


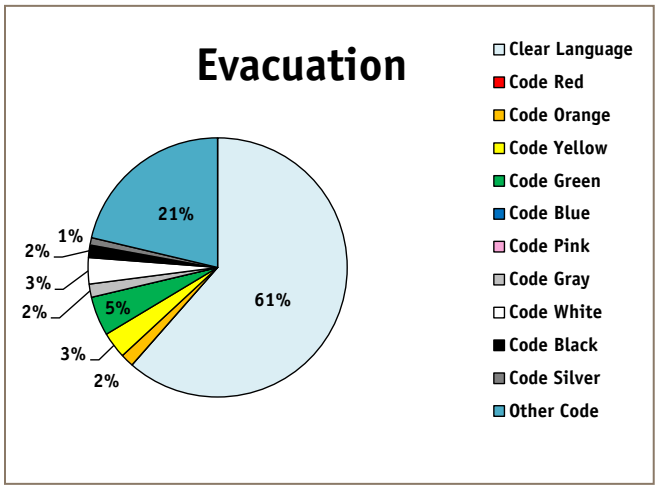





Abduction
13%
1%
38%
46%
1%
1%
Clear Language
Code Red
Code Orange
Code Yellow
Code Green
Code Blue
Code Pink
Code Gray
Code White
Code Black
Code Silver
Other Code


Security
19%
1%
6%
5%
18%
4%
6%
6%
7%
28%
Clear Language
Code Red
Code Orange
Code Yellow
Code Green
Code Blue
Code Pink
Code Gray
Code White
Code Black
Code Silver
Other Code


Hazardous Spill
30%
23%
2%
3%
2%
9%
31%
Clear Language
Code Red
Code Orange
Code Yellow
Code Green
Code Blue
Code Pink
Code Gray
Code White
Code Black
Code Silver
Other Code


Evacuation
21%
1%
2%
3%
2%
5%
3%
2%
61%
Clear Language
Code Red
Code Orange
Code Yellow
Code Green
Code Blue
Code Pink
Code Gray
Code White
Code Black
Code Silver
Other Code

APPENDIX D: HOSPITAL PARTICIPATION PLEDGE

MISSOURI HOSPITAL ASSOCIATION
STANDARDIZED EMERGENCY CODE PLEDGE

I am pleased to announce that _____
HOSPITAL NAME
is participating in the Missouri Hospital Association initiative to standardize plain language emergency codes across Missouri. Hospital personnel often are employed or practice at more than one health care facility, and variation among emergency codes increases the potential for error, resulting in a risk to patient, employee and visitor safety. To reduce variation, _____
HOSPITAL NAME
is adopting the following standardized emergency codes.

CHECK ALL CODES ADOPTED WITH THIS PLEDGE

☑	Event	Recommended Plain Language	Alternate Code
FACILITY ALERT			
	Evacuation	"Facility Alert + Evacuation + Descriptor (location)"	None
	Fire	"Code Red + Descriptor (location)"	Plain Language
	Hazardous Spill	"Facility Alert + Hazardous Spill + Descriptor (location)"	Code Orange
WEATHER ALERT			
	Severe Weather	"Weather Alert + Descriptor (threat/location) + Instruction"	None
SECURITY ALERT			
	Abduction	"Security Alert + Descriptor (threat/location)"	Code Pink
	Missing Person	"Security Alert + Descriptor"	None
	Armed Violent Intruder/Active Shooter/Hostage	"Security Alert + Descriptor (threat/location)"	Code Silver
	Bomb Threat	"Security Alert + Descriptor (threat/location)"	Code Black
	Combative Patient/Person	"Security Alert + Security Assistance Requested + (location)"	None
MEDICAL ALERT			
	Mass Casualty	"Medical Alert + Mass Casualty + Descriptor"	None
	Medical Decontamination	"Medical Alert + Medical Decontamination + Descriptor"	None
	Medical Emergency	"Code Blue + Descriptor (location)"	Plain Language

_____ CEO NAME

_____ CEO SIGNATURE

_____ HOSPITAL NAME

_____ DATE

APPENDIX E: SAMPLE HOSPITAL CHECKLIST

Nine Months Before Implementation: AWARENESS

- ❑ Draft a letter from the CEO or governance board and disseminate widely among hospital employees and key external stakeholders.
- ❑ Include an announcement in the employee newsletter.
- ❑ Recognize any employees or committees that will help implement the plain language codes.
- ❑ Announce a "go-live" date.

Eight Months Before Implementation: ESTABLISH COMMITTEE

- ❑ Authorize a committee to review and update all policies.
- ❑ Authorize a committee to review and update all hospital materials.
- ❑ Authorize a committee or individuals to update the hospital emergency operations plan.
- ❑ Authorize a committee or individuals to update all code cards, flip charts, posters or other emergency management tools.
- ❑ Authorize a committee or individuals to update all telecommunication scripts, algorithms and materials.
- ❑ Develop a formal education plan for all employees.
- ❑ Identify train-the-trainers to serve as educators and champions, announce the trainers' names to hospital employees and schedule the trainer training.
- ❑ Establish and promote mechanisms for broad-based, frequent organizational communication, which may include the following:
  - ❑ periodic staff emails
  - ❑ periodic newsletter articles providing updates and progress
  - ❑ develop posters, flyers or other materials that include the "go-live" date

Seven Months Before Implementation: DEVELOP TRAINING

- ❑ Conduct train-the-trainer competency-based training.
- ❑ Finalize education plan.
- ❑ Develop draft education materials; do not mass produce.
- ❑ Provide update to hospital governance board, leadership team and key external stakeholders.

Six Months Before Implementation: FINALIZE POLICY AND TESTING

- ❑ Begin pilot testing hospital employee training.
- ❑ Revise training plan and materials based on pilot testing.
- ❑ Schedule organizationwide training sessions.
- ❑ Finalize and produce education materials.
- ❑ Finalize policies.

Five Months Before Implementation: TRAINING DISSEMINATION

- ❑ Begin organizationwide training.
- ❑ Disseminate all materials to each hospital department.
- ❑ Disseminate all revised policies.
- ❑ Begin to disseminate posters, flyers and other awareness materials.
- ❑ Consider a challenge between hospital departments to complete training requirements.

Four Months Before Implementation: UPDATES

- ❑ Provide an update in the employee newsletter on the progress, include the "go-live" date.
- ❑ Continue with competency-based education.
- ❑ Continue to disseminate posters, flyers and other awareness materials.
- ❑ Update hospital governance and key external stakeholders as appropriate.

Three Months Before Implementation: FINALIZE

- ❑ Continue organizationwide training.
- ❑ Continue communication through posters, newsletters, staff meetings and other forums as appropriate.

Two Months Before Implementation: REINFORCE

- ❑ Complete organizationwide training.
- ❑ Continue communication through posters, newsletters, staff meetings and other forums as appropriate.
- ❑ Ensure updated policies are available for all hospital employees.
- ❑ Ensure the emergency operations plan has been updated and formally adopted.
- ❑ Ensure all emergency management tools and resources have been updated.
- ❑ Ensure all telecommunication scripts, algorithms and materials have been updated.
- ❑ Ensure public safety partners (fire, police, EMS) are aware of the new policies, codes and "go-live" date.

One Month Before Implementation: PREPARE FOR GO-LIVE DATE

- ❑ Begin a daily or weekly countdown until the "go-live" date.
- ❑ Develop a mechanism to ensure clarification of any questions.
- ❑ Ensure all department managers are ready to implement the new codes.
- ❑ Provide broad communitywide articles to educate the public on this change.
- ❑ Display awareness materials with the "go-live" date throughout the organization.
- ❑ Ensure trainers are available to answer questions.
- ❑ Communicate readiness to hospital governance and leadership team.
- ❑ Recognize employees and committees for their work to ensure a successful implementation.

IMPLEMENTATION

One Month Post Implementation: INITIAL EVALUATION

- ❑ Congratulate and recognize employees and committees for leading a successful implementation.
- ❑ Congratulate and recognize all employees for a successful implementation.
- ❑ Assess adoption of plain language codes in staff meetings, education sessions and leadership team meetings.
- ❑ Conduct department drills to assess adoption during the first five months.

Six Months Post Implementation: EVALUATION

- ❑ Conduct an organizationwide drill to assess adoption six months post-implementation.

APPENDIX F: SAMPLE HOSPITAL POLICY

Subject: Hospital Emergency Operations **Policy Number:** _____

Effective Date: _____ **Dates of Revision:** _____

Authorized Approval: _____

Policy Name: Standardized Emergency Codes

Purpose: This policy is intended to provide all staff specific guidance and instruction on how to initiate an emergency code within the hospital.

Policy Objectives: The purpose of standardized, plain language emergency codes among Missouri hospitals is to:

- reduce variation and the potential for error among Missouri hospital staff who may work or have privileges in more than one facility
- promote transparency of safety protocols for employees, patients and visitors

Definitions

Policy: In the event of an emergency situation, a plain language emergency code will be used to notify the appropriate individuals to initiate an immediate and appropriate response based on the hospital emergency operations plan. The emergency code activation may or may not include widespread notification, based on the incident and established emergency procedures.

Procedures

1. **Initiating an Emergency Code Call**
   When initiating an emergency code call, the [hospital] employee should:
   A. initiate the notification process for the specific emergency, as outlined in the emergency operations plan
   B. use the plain language code to reduce confusion
   C. use the established code script
      i. Facility Alert
         a. Evacuation: "facility alert + evacuation + location"
         b. Fire: "Code Red + location"
         c. Hazardous Spill: "facility alert + hazardous spill + location"
      ii. Weather Alert
         a. "Weather alert + descriptor (threat/location) + instructions"
      iii. Security Alert
         a. Abduction: "security alert + abduction + location"
         b. Violent Intruder: "security alert + descriptor (threat/location) + instructions"
         c. Bomb Threat: "security alert + bomb threat + instructions"
         d. Combative Person/Patient: "security alert + security assistance requested + location"
      iv. Medical Alert
         a. Mass Casualty: "medical alert + mass casualty + descriptor (location/instructions)"
         b. Medical Emergency: "Code Blue + location"

2. Terminating an Emergency Code

A. Once the emergency situation has been effectively managed or resolved, and based on the emergency operations plan, the code should be canceled. An indication of "all clear" should be sent to all that received the initial notification. This command should be repeated three times.

B. The cancelation notification should be sent via the same notification process as the initial code activation. For example, if an overhead paging system was used to activate the code, the overhead paging system should be used to cancel the code.

3. Providing Competency-based Staff Education

Competency-based education about the plain language emergency codes should be provided to all employees during employee orientation and reviewed during annual life-safety updates. Physicians, public safety officers and other contract employees also should be provided education. Education should include the following.

A. four categories of alerts (facility, weather, security, medical)

B. immediate steps for emergency code activation and notification of appropriate personnel based on the [hospital] emergency operations plan

C. specific responsibilities, based on their job description as written in the emergency operations plan

References

Healthcare Association of Southern California (2011) Health care emergency codes: a guide for code standardization, (3rd ed). Retrieved February 8, 2013, from *www.HASC.org*.

Minnesota Hospital Association (n.d.) Plain language emergency overhead paging: implementation toolkit. Retrieved February 8, 2013, from *www.mnhospitals.org/patient-safety/current-safety-quality-initiatives/emergency-overhead-pages*.

APPENDIX G: SAMPLE HOSPITAL COMPETENCY CHECKLIST

COMPETENCY CHECKLIST (SAMPLE)

Employee Name: _____ **Employee Number:** _____

Title: _____ **Unit:** _____

Skills Validation Method of Evaluation: DO-Direct Observation VR-Verbal Response WE-Written Exam OT-Other			
Emergency Code Standardization Process	**Method of Evaluation**	**Initials**	**Comments**
Patient, staff and visitor safety			
Access to emergency code policy and procedure			
Definitions of each emergency code			
How to call each emergency code			
When it is appropriate to call each code			
Staff responsibilities after calling or hearing a code			

Name of Skills Validator: _____

Signature of Skills Validator: _____ **Date:** _____

I received a copy of the Standardized Emergency Codes (Policy or Badge-Buddy).
I understand the Emergency Code procedures for the hospital and my role in safety.
I agree with this competency assessment.
I will contact my supervisor, manager or director, if I require additional training in the future.

Employee Signature: _____ **Date:** _____

Reference

Healthcare Association of Southern California (2011) Health care emergency codes: a guide for code standardization, (3rd ed). Retrieved February 8, 2013, from *www.HASC.org.*

Minnesota Hospital Association (n.d.) Plain language emergency overhead paging: implementation toolkit. Retrieved February 8, 2013, from *www.mnhospitals.org/patient-safety/current-safety-quality-initiatives/emergency-overhead-pages.*

APPENDIX H: SAMPLE HOSPITAL POSTER

A sample hospital poster template is provided on Page 35.

Emergency Codes

FACILITY ALERT

Event	Recommended Plain Language	Alternate Code
Evacuation	"Facility Alert + Evacuation + Descriptor (location)"	None
Fire	"Code Red + Descriptor (location)"	Plain Language
Hazardous Spill	"Facility Alert + Hazardous Spill + Descriptor (location)"	Code Orange

WEATHER ALERT

Event	Recommended Plain Language	Alternate Code
Severe Weather	"Weather Alert + Descriptor (threat/location) + Instruction"	None

SECURITY ALERT

Event	Recommended Plain Language	Alternate Code
Abduction	"Security Alert + Descriptor (threat/location)"	Code Pink
Missing Person	"Security Alert + Descriptor"	None
Armed Violent Intruder/ Active Shooter/Hostage	"Security Alert + Descriptor (threat/location)"	Code Silver
Bomb Threat	"Security Alert + Descriptor (threat/location)"	Code Black
Combative Patient/Person	"Security Alert + Security Assistance Requested + (location)"	None

MEDICAL ALERT

Event	Recommended Plain Language	Alternate Code
Mass Casualty	"Medical Alert + Mass Casualty + Descriptor"	None
Medical Decontamination	"Medical Alert + Medical Decontamination + Descriptor"	None
Medical Emergency	"Code Blue + Descriptor (location)"	Plain Language

APPENDIX I: FAQS

Why is the Missouri Hospital Association endorsing and leading an initiative to adopt standardized, plain language emergency codes?

MHA and member hospitals are committed to increasing patient, employee and visitor safety during any incident. The need to standardize emergency codes had been recognized by hospital emergency preparedness staff, especially in communities with more than one hospital or adjacent to nearby states. The decision to adopt plain language was proactive and based on literature, research and early trends among hospitals to promote transparency and safety. The early trend aligns with new federal initiatives to adopt plain language standards.

How did MHA develop these specific codes for standardized use?

MHA asked for volunteers from the 134 hospitals that submitted the 2012 annual emergency preparedness survey. Among those respondents, 30 hospitals agreed to have representation on the committee; this included critical access hospitals and large health care systems. MHA facilitated the process, and the group, which first convened in July 2012, met regularly to develop the plain language standardized code recommendations. Consensus and voting were the two primary methods used for decision making.

Why is plain language important?

The adoption of plain language promotes transparency, increases safety and aligns with national initiatives. The Institute of Medicine considers plain language a central tenet of health literacy (2004). The National Incident Management System also has established plain language requirements for communication and information management among emergency managers (2008).

Why did the Missouri recommendations maintain two color codes: code red for fire and code blue for medical emergencies?

The standardized emergency code workgroup determined these two codes are so common and institutionalized that maintaining these two color codes would reduce resistance, increase compliance and would not negatively affect patient, employee or visitor safety. It is important to note the workgroup did recommend plain language as the only acceptable alternative for these two codes.

Does use of plain language create additional fear among patients and visitors?

Although this is a commonly expressed concern, research suggests that plain language does not create additional fear among patients and visitors. In fact, it may decrease uncertainty among patients and visitors.

Does use of plain language reduce patient privacy or protection?

If policy implementation adheres to principles of privacy and HIPAA, use of plain language should not adversely affect patient privacy.

How should a hospital determine which emergency codes to announce to all patients, visitors and employees and which emergency codes to announce to only specific hospital personnel?

It is important that each hospital consult its emergency management and leadership teams to determine appropriate policies and procedures for the organization. As a general rule, the trend is to reduce the amount of overhead paging and announce overhead only those codes that at least the majority of patients, employees and visitors should be aware of and prepared to respond.

How should hospitals handle security issues such as an armed violent intruder?

It is important that each hospital consult its emergency management and leadership teams to determine appropriate policies and procedures for the organization. As a general rule, hospitals should consider overhead announcements when there is a confirmed or likely armed violent intruder.

Is adoption of any or all of these plain language emergency codes mandatory?

Although this initiative is strongly encouraged and endorsed by the MHA Board of Trustees, there is no regulation requiring adoption of any or all of these standardized, plain language emergency codes.

Is there a time line to implement plain language?

There is a target date of Jan. 1, 2014, for hospitals to implement these emergency codes.

References and Acknowledgements

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MacKenzie, D.J., Galbrun, L. (2007). Noise levels and noise sources in acute care hospital wards. Building Services Engineering Research and Technology. 28:117-131. Doi:10.1177/0143624406074468.

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