



Position Statement

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Plain Language Emergency Alerts

Description

Emergency alert codes (e.g., “Code Blue,” “Code Red”) are widely used in hospitals worldwide to quickly and efficiently direct staff to critical situations without alarming patients and visitors. However, their lack of standardization has resulted in a remarkably wide range of code words being used to designate a relatively small number of critical situations even among hospitals in the same area. For example, in Pennsylvania healthcare facilities between 2004 and 2013, 80 different emergency codes designated 37 different functional categories, creating 154 combinations of terminology and intended meaning.¹ Among them were 15 different codes for “combative person,” 15 for “internal/external emergency,” and 15 for adult medical emergencies. “Code Yellow” had 10 different possible meanings, “Code Orange” had nine, and “Code Purple,” “Code White,” and “Code Silver” each had seven. In addition, not all the codes were color codes — Pennsylvania hospitals also used 16 different letter codes (“Code A,” “Code O,” etc.), four different names (“Dr. Gray,” “Dr. Quick,” etc.), 12 different numbers (“Code 1,” “Code 222,” etc.), and 22 different words (“Code Alpha,” “Code Wintergreen,” etc.).¹ Pennsylvania is not alone. Studies of at least 22 U.S. states, Puerto Rico,² and multiple countries³⁻⁶ have found similar situations. California, which in 1999 was one of the first states to confront the issue, found that its hospitals had 47 different codes for infant abduction and 61 different codes for a combative person.⁷

This so-called “code confusion” is of critical importance because many healthcare workers work at multiple facilities in any given year, whether because they are travel nurses, resident physicians or fellows, or they work multiple jobs. Remembering the meanings and protocols for a broad range of codes can be difficult under any circumstances, but is all the more so when two sets of codes are involved and one has to remember, for instance, if the “Code Green” that was just called means “oxygen system failure” or “violent incident.”⁸

One solution to this decades-old problem is plain language emergency alerts. In addition to eliminating code confusion entirely, plain language alerts are easily adaptable to novel situations and they provide specific instruction about what hearers need to do, without compromising preordained response protocols. For these reasons, the Department of Homeland Security,⁹ the National Incident Management System,¹⁰ the FBI,¹¹ The Joint Commission,¹² and 10 state hospital associations (Colorado, Florida, Iowa, Kansas, Minnesota, Missouri, North Carolina, South Carolina, Texas, and Wisconsin) have advocated for the use of plain language alerts.

ENA Position

It is the position of the Emergency Nurses Association that:

1. Plain language for emergency alerts be adopted by all hospitals.
2. State Hospital Associations advocate for the use of plain language alerts in all hospitals.
3. State-level ENA chapters advocate for the use of plain language alerts in all hospitals within their states.

Background

The use of codes to activate in-hospital emergency response teams began more than a half century ago.^{13,14} “Code Blue,” the alert that is most widely and consistently used by hospitals in the U.S., was coined in 1960.^{15,16} It did not take long for code confusion to set in. Calls to standardize the plethora of emergency alert codes began in 1968, if not before.¹⁷

The difference between coded alerts and plain language alerts can be seen in the contrast between active shooter situations at West Anaheim Medical Center (WAMC) in 1999 and at Brigham and Women’s Hospital in 2015. At WAMC, there was no



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specific color code for an active shooter,^{7,18} and the coded alert system, by its very nature, prohibited adaptation of established codes to novel situations. As a result, “Code Gray” was announced, which indicated the presence of a combative person. However, the Code Gray protocol at WAMC directed male staff members to respond and help control the situation, which drew them toward the shooter and resulted in two of them being killed.^{19,20}

Brigham and Women’s hospital, on the other hand, had replaced coded alerts with plain language alerts prior to the 2015 active shooter incident. Their overhead emergency alert stated, “A life-threatening situation now exists at Watkins Clinic B, Shapiro 2. All persons should immediately move away from that location if it is safe to do so. If it is not safe to move away, shelter in place immediately.”²¹ In addition to its clarity and specific instruction, the Brigham and Women’s alert relieved hospital staff of the task of communicating to every patient and visitor what “Code Gray” meant and what they needed to do about it while also executing the active shooter protocols.

Healthcare workers are far more likely than the general population to have multiple employers. Nearly 200,000 nurses across the U.S. hold multiple jobs,²² and a 2013 survey found that between 25% and 40% of physicians (depending on the specialty) are employed at more than one healthcare facility.²³ The same applies to respiratory therapists, social workers, nursing assistants, housekeeping personnel, and other hospital staff.²⁴ The resulting danger of code confusion is real, and adverse events have been reported.^{39,40} For example, a part-time nurse who worked in multiple Washington State hospitals called a “Code Blue” for a patient who had stopped breathing, but “Code Blue” in that particular hospital meant that an armed police response was required. The nurse did not realize that “Code Blue” meant something else until the police arrived with guns drawn.³⁹ One survey of hospital staff in the Delaware Valley Region found that 41% had worked at hospitals with different codes, 40% had witnessed code confusion, and most of them were unfamiliar with the color codes for security events.²⁵ A seasoned physician and hospital CEO in Minnesota admitted that he had worked at five different hospitals during his career and never knew all of the color codes at any of them.²⁶

Opposition to plain language alerts is usually rooted in a belief that patients and visitors will panic in an emergency, so coded language will protect both them and the staff.^{25,27} However, studies of human behavior in emergency and disaster situations have shown not only that people tend not to panic, but also that they are more composed when they know what is happening and are given direction.^{11,27-31} Perhaps this is the reason that the majority of hospital patients and visitors polled in multiple surveys have said that they would prefer the transparency of plain language alerts over coded alerts.^{21,25,26}

Opposition to plain language alerts has also been founded on the belief that patients do not need to know about emergencies that do not concern them (e.g., a cardiac arrest on another floor), and that plain language alerts would constitute a stressor.²⁵ It is worth noting, however, that the majority of coded alerts indicate situations that could potentially harm patients and visitors, without alerting them as to what is happening or what they should do. All alerts other than those for medical emergencies — including alerts for an abducted baby or child³² — have potential implications for patient and visitor safety and so should be announced in plain language. As for the small number of codes that are used to designate medical emergencies, most of them are effectively plain language alerts already due to their use on TV (e.g., Code Blue) or their already-assigned plain language (e.g., Code Stroke, Code Rapid Response). In addition, multiple studies have shown that the real stressor in overhead alerts is unnecessary noise,³³⁻³⁵ so the position that patients might be stressed by overhead alerts in plain language is an argument for silencing alerts altogether, rather than an argument for using coded language.

The formulaic nature of plain language alerts (e.g., “medical emergency” + descriptor + location)²⁶ ensures that they provide a great deal of information in a short amount of time without violating HIPAA. Concerns that plain language alerts come with the security risk of alerting perpetrators to knowledge of their presence have been deemed unfounded by many security experts.^{9,11,32,36-38,40} As the Director of Security at Brigham and Women’s Hospital has said of plain language emergency alerts, “there is no downside.”²¹



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Resources

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