



PLAIN LANGUAGE IMPLEMENTATION GUIDE

Hospital Emergency Alert Events

ISSUED BY THE HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA (HASC)



EXECUTIVE LEADERSHIP DECISION SUMMARY

The Decision at Hand

Beginning in September 2026, hospitals in the HASC region are strongly encouraged to initiate implementation of standardized plain language emergency alerts for communicating emergency code events. Hospitals should transition according to organizational readiness and, upon go-live, retire legacy color-code terminology (except Code Blue) to reduce dual-system confusion.

What is Changing

- Color-coded emergency alerts (e.g., Code Red, Code Silver, Code Pink) will be retired.
- Emergency events will be communicated using plain language, clearly stating:
 - Alert type (Facility, Medical, Security)*
 - Event
 - Location
 - Any necessary instructions

** Organizations may choose to include an alert category (e.g., Facility, Medical, Security) within policies, training materials or notification formats. Inclusion of the category in overhead announcements is optional and should be determined by organizational policy, operational needs and the desire to maintain concise emergency communications.*

- Terminology will align across the HASC region to support workforce mobility, mutual aid and safety.

What is NOT Changing

Code Blue remains unchanged. It is universally recognized across healthcare, deeply embedded in clinical workflows, integrated into emergency response systems and equipment, and critical to immediate life-saving response.

- Hospitals retain flexibility to:
 - Decide which events require overhead paging
 - Customize scripts to match local workflows
 - Control implementation timing within the recommended framework

Why This Matters Now

- Workforce mobility
- Safety and clarity
- National alignment
- Patient experience

What Leadership is Being Asked to Approve

Executives are asked to:

1. Endorse the transition to plain language emergency alerts (excluding Code Blue)
2. Designate executive sponsorship and an implementation lead
3. Authorize policy, emergency operations plan (EOP), training and paging updates
4. Support organization-wide training and communications
5. Champion the change visibly to reinforce safety culture

What Implementation Looks Like (At a Glance)

- Recommended timeline: ~Nine months, adaptable to organizational readiness
- Six phases: Approval → Planning → Training Development → Organization-wide Training → Go-live → Sustainment
- Key enablers:
 - Clear governance
 - Standardized scripts
 - Robust communication
 - Competency-based training
 - Post-implementation evaluation

Risks of Partial or Delayed Adoption

- Continued terminology inconsistency across facilities
- Staff confusion during high-risk events
- Increased patient, visitor and workforce safety risk
- Missed opportunity to align with regional and national best practices

The Bottom Line

This initiative strengthens patient safety, workforce readiness and regional interoperability. Executive sponsorship is the most important predictor of successful implementation.

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HOW TO USE THIS GUIDE

This implementation guide is designed to support hospitals in the Hospital Association of Southern California (HASC) region as they transition from traditional color-coded emergency alerts to standardized **plain language emergency alerts**. The guide provides practical instructions, templates, tools and timelines to help hospital leaders, emergency managers safety and security managers and staff implement this important safety initiative in an organized and consistent manner.

Use this guide as a roadmap to plan, execute and sustain the transition within your facility.

Primary Owners and Key Contributors

Successful transition to plain language emergency alerts requires clear ownership and coordinated participation across the organization. Hospitals are encouraged to designate primary accountability for implementation, with defined roles to support planning, execution and sustainment.

Who This Guide is For

This guide is intended for individuals responsible for emergency management, operations, safety, security, communications and staff training, including:

- Hospital executives and governance
- Emergency management and safety officers
- Nursing and clinical leadership
- Security and facilities teams
- Communications / public affairs
- Human resources and training departments
- IT and telecommunications staff
- Department managers and unit leaders

Each of these groups plays a critical role in ensuring a smooth and coordinated transition.

How to Get Started

To begin implementation:

- Confirm executive approval and identify your internal implementation leads
- Establish committees responsible for policy, training, operations and communications
- Review your existing color-code system and identify updates needed for alignment
- Use the framework to schedule activities based on your hospital's target go-live date
- Begin developing or customizing training and communication materials for staff
- This guide is designed to be flexible. Facilities may adapt the timeline or approach to best meet organizational needs, capacity and readiness.

EXECUTIVE SUMMARY

Patient, medical staff, volunteer and visitor safety remains a top priority for the Hospital Association of Southern California (HASC). Although not mandated, HASC encourages member hospitals to initiate implementation of standardized plain language emergency alerts beginning in September 2026, based on organizational readiness.

For decades, hospitals have relied on color-coded emergency alerts to signal critical events. While these alerts are familiar to many clinicians, increasing workforce mobility, traveler staffing and regional mutual aid have highlighted the need for a more consistent and easily understood system. Plain language emergency alerts reduce ambiguity, support rapid decision making and align with national best practices in emergency communication.

HASC's Safety and Security Committee first introduced standardized healthcare emergency alerts for California in 2000 and later revised them in 2014. These color codes were accompanied by implementation guides, checklists and resources to help hospitals align them with internal policies and procedures. The standardized color codes included:

BLUE – Adult medical emergency
GRAY – Combative person
GREEN – Patient elopement
ORANGE – Hazardous materials spill/release
PINK – Infant abduction
PURPLE – Child abduction
RED – Fire
SILVER – Person with a weapon / active shooter / hostage
TRIAGE EXTERNAL – External disaster
TRIAGE INTERNAL – Internal disaster
WHITE – Pediatric medical emergency
YELLOW – Bomb threat

As hospitals implemented these codes, significant variation still developed across facilities. Many hospitals added new codes, modified definitions or used different naming conventions. In 2025, at the request of member hospitals, HASC convened clinical, facility, emergency management and communications experts to assess the current landscape. This review identified more than 25 different emergency codes in use across the six HASC counties, underscoring the need for a unified, easily understood communication approach.

The HASC Emergency Codes Workgroup reviewed these findings and evaluated national best practices supporting plain language adoption. In May 2025, the workgroup formally supported the transition from color-coded alerts to standardized plain language emergency codes, strongly recommending that hospitals begin planning and implementing the transition starting in September 2026, based on organizational readiness.

To support this transition, HASC developed a recommended nine-month implementation timeline with clear activities, milestones and tools to help hospitals prepare, train staff, update policies and communicate effectively. The objectives of this initiative include:

- Aligning hospital emergency communication with national plain language and safety standards
- Reducing variability in emergency alert terminology across Southern California hospitals
- Improving safety for patients, visitors and staff through clear, consistent emergency communication

Beginning in September 2026, hospitals across the HASC region are encouraged to initiate implementation of standardized plain language emergency alerts based on organizational readiness. This regional initiative aims to establish consistent, easily understood emergency terminology across Southern California hospitals to support patient safety, workforce mobility and interoperability.

Code Blue is the sole exception to this transition and will be retained in its historical form. Code Blue is universally recognized within healthcare, is time critical in nature and is deeply embedded in clinical workflows, medical response training and life-sustaining equipment and technology. Maintaining Code Blue ensures uninterrupted clinical response, avoids risk associated with retraining during high acuity events and preserves system reliability across teams, facilities and devices.

Key Local Decisions Hospitals Must Make

- Which alerts are announced
- When instructions are included
- How **Code Blue** is operationally separate
- How alerts are communicated to targeted responders versus the general population
- Who has authority to activate and cancel alerts

PLAIN LANGUAGE EXPLANATION

Research shows that withholding or delaying information during emergencies can increase uncertainty, fear and ineffective response behaviors. (Proulx & Sime, 1991; CDC, 2014)

Effective communication, on the other hand, reduces anxiety, supports appropriate behavior and helps populations respond more calmly in times of crisis (Burbach, 2017; Perry and Lindell, 2003)

Clear and straightforward communication, often called plain language, is critical for ensuring messages are easily understood the first time they are read or heard. Plain language means using simple, direct wording that fits the subject matter and the intended audience, while avoiding jargon, overly complex explanations, abbreviations or acronyms.

In 2010, the Federal Plain Language Guidelines became law to strengthen public trust in federal agencies by ensuring government communication is easy to understand and use. Agencies such as the Department of Homeland Security (DHS), Federal Emergency Management Agency (FEMA), National Incident Management System (NIMS), Cybersecurity & Infrastructure Security Agency (CISA), Department of Health and Human Services (HHS) and Centers for Disease Control and Prevention (CDC) all advocate for plain language. They emphasize its role in improving clarity, reducing misunderstandings and ensuring consistent communication in emergencies, including the recommendation that hospitals adopt plain language emergency alerts.

Within hospital settings, plain language plays a vital role in safety and emergency response. It promotes clarity, reduces fear, supports inclusiveness and ensures compliance with patient safety regulations. In high-stress situations, staff, patients and visitors must receive clear instructions to grasp the urgency of the event and respond appropriately. Medical jargon or technical codes can cause unnecessary confusion or distress, while plain language reduces ambiguity and directs attention to the actions required. It also helps ensure that individuals with limited English skills, cognitive challenges or sensory impairments have equal access to emergency information.

Time is often limited during emergencies. Using plain language speeds up decision-making and minimizes the chance of misinterpretation. Regulatory authorities also support plain language standards in hospital emergency management to strengthen patient safety and adherence to compliance requirements. Ultimately, it enhances communication, lessens stress and improves safety for everyone

One common objection to adopting plain language alerts in healthcare is the assumption that patients and visitors will become more anxious if they hear them. Effective communication, on the other hand, reduces anxiety, supports appropriate behavior and helps populations respond more calmly in times of crisis (Burbach, 2017; Perry and Lindell, 2003).

This guidance follows an **all-hazards approach** to emergency communication, recognizing that hospitals must be prepared to respond to a wide range of events using a consistent and reliable communication structure. Plain language emergency alerts support this approach by allowing the same alert framework to be applied across different hazards while enabling hospitals to tailor operational response based on the specific situation.

DEVELOPMENT OF EVENTS

The HASC Emergency Alerts Workgroup's development of plain language emergency alerts leveraged the following considerations:

- Certain emergency situations will need to be heard by all staff, visitors and patients.
- Some emergency alerts may have additional instructions or directions.
- Hospitals may choose what overhead emergency alert communications they use.
- The transition from color-code emergency events to plain language will require policy and plan revisions along with staff awareness and education.

The transition from color-coded events to plain language was organized using three alert categories to support policy development, training and implementation planning.

These categories provide a framework for grouping emergency events and may be incorporated into organizational notification formats as determined by local policy. Inclusion of the alert category in overhead announcements is optional.

Hospital: Alerts that support the safety of patients, staff and visitors and include the management of essential plant operations, utilities or campus-wide conditions.

Medical: Alerts that support clinical care and response activities for patients and incident victims while maintaining the safety of staff, patients and visitors.

Security: Alerts that address situations posing an actual or potential threat to the safety and security of staff, patients, visitors or others within the healthcare facility.

GRAY – Combative person
 GREEN – Patient elopement
 ORANGE – Hazardous materials spill/release
 PINK – Infant abduction
 PURPLE – Child abduction
 RED – Fire
 SILVER – Person with a weapon / active shooter / hostage
 TRIAGE EXTERNAL – External disaster
 TRIAGE INTERNAL – Internal disaster
 WHITE – Pediatric medical emergency
 YELLOW – Bomb threat

Beginning in **September 2026**, hospitals in the HASC region are strongly encouraged to initiate implementation of standardized plain language emergency alerts based on organizational readiness. Hospitals should transition according to their implementation timeline and, upon go-live, retire legacy color-code terminology (except Code Blue) to reduce dual-system confusion.

Each alert should clearly communicate the event, location and any necessary instructions or directions. Alert categories (Hospital, Medical, Security) may be used for organizational purposes and are optional in overhead announcements.

Public Versus Targeted Communication

Hospitals should distinguish between emergency alerts intended for general awareness and safety of patients, visitors and staff, and operational communications intended for targeted responders.

Overhead paging and other public-facing communications should focus on clearly describing the event and location, with brief instructions included only when immediate life safety action is required.

Detailed operational instructions and responder specific actions should be communicated through established internal communication channels and not announced overhead.

COLOR CODE → PLAIN LANGUAGE MAPPING TABLE

This chart provides a side-by-side comparison of former color-coded emergency alerts and their corresponding plain language alert terminology. The intent of this transition is to improve understanding among staff, patients and visitors by clearly describing emergency events using commonly understood language. Hospitals may use this chart to update policies, overhead paging scripts, staff training materials, signage and reference tools. To apply the chart, identify the color code currently in use and transition to the corresponding plain language alert listed.

Plain language alerts are designed to clearly communicate what is happening, where it is happening and any necessary instructions.

Plain language alerts are designed to clearly communicate **what is happening, where it is happening and any necessary instructions**, without relying on coded terminology or internal response structures. Organizations may use alert categories (Hospital, Medical, Security) for policy, training or notification purposes; however, inclusion of the category in overhead announcements is optional.

Code Blue is the only exception to this transition and will be retained due to its longstanding, universally understood clinical and operational significance.

This chart should be incorporated into staff education, exercises and onboarding to ensure consistent understanding and appropriate use of the revised alert terminology.

HOSPITAL ALERTS

FORMER COLOR CODE / TERM	ORIGINAL MEANING		PLAIN LANGUAGE ALERT TYPE AND EVENT	GUIDANCE / NOTES
CODE RED	Fire	→	Hospital Alert – Fire Alarm – [Location]	Use “Follow fire alarm procedures.” Avoid default evacuation language to reduce unnecessary movement during false alarms.
CODE ORANGE	Hazardous materials spill or release	→	Hospital Alert – Hazardous Materials Incident – [Location]	Include affected area. Use “Avoid the area and await instructions.”
INTERNAL TRIAGE	Internal disaster	→	Hospital Alert – Emergency Response Underway – Hospital-wide	Plain language description of an internal emergency event requiring hospital-wide response coordination.
EXTERNAL TRIAGE	External disaster	→	Hospital Alert – Incoming Emergency Patients – Emergency Department	Plain language description of increased patient arrivals; does not suggest risk to those inside the hospital.

SECURITY ALERTS

FORMER COLOR CODE	ORIGINAL MEANING		PLAIN LANGUAGE ALERT TYPE AND EVENT	GUIDANCE / NOTES
CODE GRAY	Combative / violent person	→	Security Alert – Combative Person – [Location]	Use when behavior presents a safety risk. Avoid unnecessary descriptors that could escalate anxiety.
CODE SILVER	Active shooter	→	Security Alert – Active Shooter – [Location]	Immediate life-threatening event. Short directive may be included when appropriate (e.g., “Run or hide. Fight. This is not a drill.”).
CODE SILVER	Person with weapon	→	Security Alert – Person with a Weapon – [Location]	Used when a weapon is present but active shooter criteria are not met; differentiation reduces over-escalation.
CODE SILVER	Hostage situation	→	Security Alert – Hostage Situation – [Location]	Separate alert improves clarity and supports law enforcement coordination.
CODE GREEN	Patient elopement	→	Security Alert – Patient Elopement – [Location]	Include last known location and description only when operationally appropriate; balance awareness with privacy.
CODE PINK	Infant abduction	→	Security Alert – Missing Infant – [Location]	Nationally recognized terminology; clear to staff, patients and visitors.
CODE PURPLE	Child abduction	→	Security Alert – Missing Child – [Location]	Specify age and last known location when appropriate.
CODE YELLOW	Bomb threat	→	Security Alert – Bomb Threat – [Location]	Avoid automatic evacuation language. Use “Follow security instructions.”

MEDICAL ALERTS

FORMER COLOR CODE / TERM	ORIGINAL MEANING		PLAIN LANGUAGE ALERT	GUIDANCE / NOTES
CODE STROKE	Stroke	→	Medical Alert – Stroke Patient – [Location]	Removes clinical shorthand while retaining urgency. “Stroke response team responding” optional per policy.
CODE STEMI	ST-elevation myocardial infarction (heart attack)	→	Medical Alert – STEMI Patient – [Location]	Widely recognized clinical terminology. Organizations may use “heart attack patient” if preferred for greater public understanding.
CODE WHITE	Pediatric medical emergency	→	Medical Alert – Pediatric Emergency – [Location]	Plain language preferred; avoids unexplained codes.
CODE BLUE (exception)	Adult cardiac / respiratory arrest		Code Blue – [Location] (retained)	Code Blue retained; see Executive Summary for rationale.

OVERHEAD PAGING SCRIPT EXAMPLES

Use of Instructions in Overhead Emergency Alerts

Instructions should be included in overhead emergency alerts **only when immediate life safety action is required** by patients, visitors or staff who are not part of the response. When used, instructions must be brief, clear and action-oriented. Alerts that do not require immediate public action **should announce the alert type, event and location only**, with operational or responder specific instructions communicated through internal channels.

Organizations may choose to include an alert category (Hospital, Medical, or Security) in notification formats; however, inclusion of the category in overhead announcements is optional and determined by organizational policy.

HOSPITAL ALERTS

ALERT EVENT	STANDARD OVERHEAD PAGING SCRIPT
Fire Alarm	“Hospital Alert – Fire Alarm – Second Floor East”
Hazardous Materials Incident	“Hospital Alert – Hazardous Materials Incident – Central Supply”
Emergency Response Underway (Internal Disaster)	“Hospital Alert – Emergency Response Underway – Hospital-wide.”
Incoming Emergency Patients (External Disaster)	“Hospital Alert – Incoming Emergency Patients – Emergency Department.”
Restricted Access	“Hospital Alert – Restricted Access – West Campus, Second Floor.”

MEDICAL ALERTS

ALERT EVENT	STANDARD OVERHEAD PAGING SCRIPT
Heart Attack Patient (STEMI)	“Medical Alert – Heart Attack Patient – Emergency Room Five.”
Code Blue (<i>Exception</i>)	“Code Blue – Critical Care East.”
Rapid Medical Response	“Medical Alert – Rapid Medical Response – Transitional Care Unit, Room One.”
Stroke Patient	“Medical Alert – Stroke Patient – Emergency Room Two.”
Severe Infection (Sepsis)	“Medical Alert – Severe Infection Patient – Emergency Bay Four.”
Trauma Patient (Full Activation)	“Medical Alert – Trauma Patient – Emergency Department.”

SECURITY ALERTS

ALERT EVENT	STANDARD OVERHEAD PAGING SCRIPT
Active Shooter	“Security Alert – Active Shooter – West Entrance.”
Person with a Weapon	“Security Alert – Person with a Weapon – East Wing, Second Floor.”
Hostage Situation	“Security Alert – Hostage Situation – Emergency Room Five.”
Combative Person	“Security Alert – Combative Person – North Campus Entrance.”
Missing Infant	“Security Alert – Missing Infant – Mother/Baby Unit.”
Missing Child	“Security Alert – Missing Child – Pediatric Unit.”
Missing Adult	“Security Alert – Missing Adult – Fourth Floor Medical Unit.”
Patient Elopement	“Security Alert – Patient Elopement – South Wing, Third Floor.”
Bomb Threat	“Security Alert – Bomb Threat – West Campus, Pediatric Unit – Follow security instructions.”
Security Assistance Needed	“Security Alert – Security Assistance Needed – Seventh Floor South.”

ALL CLEAR ANNOUNCEMENT

ALERT EVENT	STANDARD OVERHEAD PAGING SCRIPT
Universal All Clear	“All clear. The emergency event has been resolved. All clear.” (Repeat two to three times as appropriate.)

PRINCIPLES

1. **Regional Alignment and Collective Action.** The HASC Emergency Alerts Workgroup, representing hospitals across Southern California, has endorsed this safety initiative as part of its ongoing commitment to improving clinical care, safety and quality. While adoption is voluntary, the workgroup encourages member hospitals to initiate implementation of standardized plain language emergency alerts beginning in September 2026, based on organizational readiness.
2. **Consistency with National Standards.** The transition from color-coded alerts to plain language aligns with national best practices advocated by federal agencies including CMS, The Joint Commission, FEMA, CDC, CISA and HHS. These agencies recognize plain language as essential for improving communication, reducing error and enhancing interoperability during emergencies across healthcare settings.
3. **Risk-based Flexibility in Wording and Script Use.** This initiative establishes standardized **alert categories and structure**, while allowing hospitals limited flexibility to adapt wording based on **facility layout, patient population and risk assessment**. Hospitals may tailor recommended scripting provided in the Hospital Emergency Alert Event Plain Language Sample Tools to fit local operational needs, provided the core intent, alert type and clarity of communication are preserved.
4. **Commitment to Safety, Inclusiveness and Appropriate Communication.** Patient, staff volunteer and visitor safety remains the priority for Southern California hospitals. Plain language communication promotes clarity, reduces fear and supports inclusiveness for diverse audiences, including individuals with limited English proficiency, cognitive impairments or sensory challenges. Each hospital should determine which emergency events require overhead public announcement based on **safety relevance, environment and patient population**, while using targeted communication channels for responder-specific instructions.
5. **Regional Standardization with a Defined Clinical Exception.** This initiative seeks to establish consistent emergency alert terminology across all hospitals in Southern California and aligns with similar efforts adopted in neighboring states. **Code Blue remains the sole exception** to this transition due to its longstanding universal clinical recognition, time-critical nature and embedded operational and technological dependencies.

NOTE

Code Blue will continue to be announced and managed as traditionally used.

CONSIDERATIONS FOR HOSPITALS

Hospitals should formally determine and document the following decisions as part of implementation:

- Which emergency events are announced overhead to patients, visitors and staff
- How response roles are defined for each event, including responder activation
- Whether follow-up instructions or an “all clear” announcement are required, consistent with the emergency operations plan
- How operational and responder-specific instructions are communicated through targeted channels

IMPLEMENTATION FRAMEWORK CHECKLIST

The transition from color-coded emergency alerts to standardized plain language emergency alerts requires deliberate planning, coordinated execution and sustained reinforcement. This checklist-based framework provides hospitals with a phased approach to guide decision-making, readiness, training, implementation and long-term adoption. While the recommended timeline spans approximately nine months, organizations may adapt activities based on facility size, layout, patient population, operational complexity and risk profile, provided decisions are intentional, documented and consistently applied.

Phase 1 PRE-IMPLEMENTATION AND ORGANIZATIONAL APPROVAL

(Initial Decision-making, Governance, Early Awareness)

- ☐ Executive leadership and hospital governance formally approve adoption of plain language emergency alerts
- ☐ Emergency preparedness committees review and endorse the transition
- ☐ CEO/board announcement issued to introduce the initiative
- ☐ Staff communications distributed (newsletter, email, huddles) announcing the transition and anticipated go-live date
- ☐ Purpose, benefits, scope and risk-based considerations of the transition communicated organization-wide
- ☐ Key stakeholders identified (clinical leadership, security, emergency management, IT/telecom, communications, HR)
- ☐ Primary implementation committee established with defined roles and accountability

PHASE COMPLETE WHEN

- ☒ Executive approval documented
- ☒ Implementation governance structure established
- ☒ Initial awareness communications completed

Phase 2**PLANNING, COMMITTEES AND
DEVELOPMENT OF MATERIALS***(Policy Review, EOP Updates, Training Strategy)*

- ☐ Subcommittees formed for policy, training, communications, operations and IT/telecom
- ☐ Existing color-coded policies reviewed for revision or retirement
- ☐ Emergency operations plan (EOP) sections impacted by the transition identified and updates drafted
- ☐ **Local decisions documented regarding which alerts are announced overhead versus communicated to targeted responders, based on safety relevance and risk assessment**
- ☐ Training strategy developed (audiences, formats, competency expectations)
- ☐ Initial drafts created for paging scripts, job aids, badge buddies, posters, FAQs and internal messaging
- ☐ Implementation milestones, deliverables and evaluation criteria defined

PHASE COMPLETE WHEN

- ☒ Draft policies and EOP revisions prepared
- ☒ Training and communication plans finalized
- ☒ Materials inventory completed

Phase 3**TRAINING DEVELOPMENT, PILOT TESTING
AND MATERIALS FINALIZATION***(Train the Trainer, Pilots, Script Finalization)*

- ☐ Train the trainer sessions conducted
- ☐ Training content pilot tested with selected departments representing **different roles, environments and risk exposure**
- ☐ Feedback collected on clarity, comprehension and usability
- ☐ Training materials, job aids, paging scripts and communication tools refined to ensure **consistency while accommodating local workflows**
- ☐ Policies, procedures and EOP updates finalized
- ☐ Paging system scripts and related technical components reviewed and approved

PHASE COMPLETE WHEN

- ☒ Training materials finalized
- ☒ Policies and EOP updates approved
- ☒ Paging scripts validated and ready for use

Phase 4

ORGANIZATION-WIDE TRAINING AND READINESS ACTIVITIES

(Full Training Rollout, Communication, System Validation)

- ☐ Mandatory training launched for staff, providers and volunteers
- ☐ Educational tools distributed (posters, badge buddies, workflow diagrams) appropriate to **clinical, nonclinical and public-facing environments**
- ☐ Countdown communications implemented (huddles, newsletters, manager talking points)
- ☐ Paging system testing completed successfully
- ☐ Signage installed in designated staff and public areas based on audience needs and safety relevance
- ☐ Staff provided access to final policies, EOP updates and reference materials
- ☐ External partners (fire, EMS, law enforcement) notified of terminology changes and local communication practices

PHASE COMPLETE WHEN

- ☒ Training completion targets met
- ☒ System readiness verified
- ☒ Facility materials deployed

Phase 5 GO-LIVE EXECUTION

(Activation, Real-time Support, Leadership Visibility)

- ☐ Executive “go live” announcement issued
- ☐ Plain language emergency alerts activated in overhead paging system per approved risk-based use criteria
- ☐ On-site or virtual support provided (champions, help lines, escalation pathways)
- ☐ Overhead announcements monitored for accuracy, consistency and appropriate use
- ☐ Frequent communications shared during initial implementation period

PHASE COMPLETE WHEN

- ☒ Go-live activation confirmed
- ☒ Staff support processes in place
- ☒ Initial issues documented and addressed

Phase 6**POST-IMPLEMENTATION EVALUATION AND
LONG-TERM SUSTAINMENT***(Evaluation, Drills, Continuous Improvement)*

- ☐ Department level drills conducted within the first month to evaluate alert use in **varied operational environments**
- ☐ Paging data reviewed for accuracy, clarity and alignment with approved terminology and usage criteria
- ☐ Staff feedback collected (surveys, meetings, focus groups)
- ☐ Training and communication materials updated based on lessons learned
- ☐ Hospital-wide drill conducted approximately six months post implementation
- ☐ Plain language emergency alerts integrated into onboarding and annual training
- ☐ Annual review and update schedule established to reflect **changes in risk, facility operations or patient population**

PHASE COMPLETE WHEN

- ☒ Post-implementation evaluation completed
- ☒ Sustainment processes embedded
- ☒ Ongoing review cadence defined

COMMUNICATION PLAN

1

PURPOSE OF THE COMMUNICATION PLAN

This communication plan ensures that all staff, patients, visitors and external partners understand and appropriately adopt plain language emergency alerts. The plan supports consistent, risk-appropriate and transparent communication before, during and after implementation to reduce confusion, improve emergency response accuracy and maintain alignment with federal and state emergency communication standards.

The plan also recognizes that hospitals differ in size, layout, patient population and risk profile, and therefore must make deliberate, documented decisions regarding how and when communications are delivered.

2

COMMUNICATION OBJECTIVES

1. **Increase Awareness.** Ensure all audiences understand what is changing and why plain language improves safety, clarity and response accuracy.
2. **Maintain Transparency with Patients and Visitors.** Use clear, simple language to explain overhead announcements in a reassuring and non-alarmist manner, appropriate to the event and audience.
3. **Prepare Staff for Implementation.** Provide structured, timely communication aligned with operational readiness and training milestones.
4. **Strengthen External Coordination.** Ensure EMS, fire, law enforcement and community partners are informed of terminology changes and local communication practices to support coordinated response.
5. **Build Competency and Confidence.** Reinforce consistent use of plain language alerts through education, tools and accessible resources.
6. **Ensure Long-term Sustainment.** Support post-implementation evaluation and reinforce communication practices to maintain compliance, readiness and consistency over time.

3 COMMUNICATION GOVERNANCE

1 Governance Team Structure

The Communication Governance Team includes representatives from:

- Emergency management
- Communications/public affairs
- Nursing and clinical leadership
- Medical staff (physician) leadership
- Human resources
- Security and facilities
- IT/telecom
- Patient experience and interpreter services

This multidisciplinary structure ensures communication decisions reflect **operational risk, clinical impact, accessibility and patient experience considerations.**

2 Roles and Responsibilities

ROLE	RESPONSIBILITIES
Executive Sponsor (CEO/COO)	Issues formal announcements and approves major messaging decisions.
Communications Lead	Drafts, coordinates and distributes messages; ensures consistency across channels and audiences.
Emergency Management Lead	Validates accuracy of emergency terminology, alert use and alignment with the emergency operations plan.
Training Lead	Ensures training materials align with communication timelines and operational readiness.
Department Managers	Conduct huddles and reinforce messaging locally based on departmental context.
Champions Network	Provides peer-to-peer clarification and models appropriate communication practices.

4 CORE AUDIENCES AND COMMUNICATION NEEDS

Communication methods should be selected based on audience needs, risk exposure and operational relevance.

AUDIENCE	PRIMARY COMMUNICATION NEEDS	CHANNELS
Employees	Understanding of new alerts, timelines and expectations	Email, intranet, huddles, posters, training
Physicians and allied health	Role-specific expectations and workflows	Medical staff briefings, newsletters
Volunteers and nonclinical staff	Clear, simple explanations	Orientation, posters, badge buddies
Patients and visitors	Reassuring, plain language explanations	Lobby signage, patient packet inserts
External agencies	Terminology and response alignment	Direct outreach, formal letters
Vendors and contracted staff	Operational awareness	Email notices, contractor briefings

5 COMMUNICATION PHASES AND TIMELINE

Across all phases, communication strategies should be adjusted based on **organizational readiness, facility complexity and patient population**, while maintaining consistency of core messaging.

6 COMMUNICATION CHANNELS AND TACTICS

Hospitals should select communication channels based on urgency, audience and need for action, limiting public facing communication to information necessary for awareness and safety.

PRIMARY CHANNELS

1. Email distributions
2. Intranet resource hub
3. Digital signage
4. Unit huddles and staff meetings
5. Posters, flyers and badge buddies
6. Educational videos
7. Paging script demonstrations
8. Champions outreach
9. Interpreter services

SECONDARY CHANNELS

1. Social media (optional; high level information only)
2. Patient portal messages
3. Town halls

7 TOOLS AND MATERIALS

Tools should be adapted based on **scope of implementation and staff roles**, while preserving standardized terminology.

8 MULTILINGUAL AND ACCESSIBILITY STRATEGY

Patient-facing materials will be adapted based on **community language needs and accessibility requirements**, consistent with equity standards.

9 METRICS AND EVALUATION

Metrics should be reviewed with consideration of **facility size, alert frequency and risk environment**, ensuring evaluation focuses on accuracy, comprehension and safe response.

10 SUSTAINMENT PLAN

Long-term communication practices should be embedded into routine operations and reviewed annually to ensure continued alignment with organizational risk, regulatory expectations and patient needs.

APPENDIX A

PLAIN LANGUAGE EMERGENCY ALERT IMPLEMENTATION RESOURCES

SAMPLE RESOURCES	PURPOSE / USE
Badge Buddy Pocket Guide	Quick reference visual tool for staff to reinforce plain language alert categories (Hospital, Medical, Security); useful during transition periods, onboarding and ongoing education.
Facility Poster	Visual education tool for staff areas and selected public locations to display approved plain language emergency alerts and support awareness among staff, patients and visitors.
Staff Education Resource (PowerPoint)	Structured training resource explaining the transition to plain language, alert structure, alert categories and staff expectations; suitable for meetings, huddles, learning management system training and onboarding.
Competency Validation	Supports validation of staff understanding and readiness; may be used during implementation, annual competency review or refresher education.
Competency Assessment	Evaluates staff comprehension and organizational readiness through knowledge checks, scenario-based questions or post-training evaluations to support continuous improvement.

NOTE

These resources may be adapted to align with hospital-specific workflows and emergency operations plans (EOPs). All materials should be reviewed and approved through established governance processes prior to implementation. **Code Blue remains the sole exception** to the transition to plain language and will continue to be used as traditionally named.

APPENDIX B

SAMPLE POLICY

Purpose: This policy provides staff with guidance for initiating, communicating and responding to emergency alerts within the hospital.

Policy Objectives: The purpose of standardized plain language emergency alerts is to:

- Reduce variation and the potential for error among staff who work, train or hold privileges at more than one healthcare facility.
- Promote clear, consistent communication during emergency situations.
- Improve understanding of emergency events among employees, patients, visitors and responders.
- Support safety, workforce mobility and regional interoperability.

Policy Statement: In the event of an emergency, a plain language emergency alert will be used to notify the appropriate individuals and initiate an immediate and appropriate response in accordance with the hospital's emergency operations plan (EOP). Emergency alert activation may or may not include widespread notification, depending on the nature of the event and established emergency procedures.

Organizations may use Hospital, Medical and Security alert categories for policy, training and communication purposes; however, inclusion of the alert category in overhead announcements is optional.

Procedures:

1. Initiating an Emergency Alert

When initiating an emergency alert, the hospital employee should:

- A. Initiate the notification process for the specific emergency as outlined in the EOP.
- B. Use approved plain language terminology to reduce confusion and improve understanding.
- C. Use the established emergency alert format.

Emergency announcements should clearly identify:

- The event
- The location
- Any necessary instructions when immediate life safety action is required

Examples:

Hospital Alerts

- Fire Alarm – Location
- Hazardous Materials Incident – Location
- Emergency Response Underway – Hospital-wide
- Utility Disruption – Location

Security Alerts

- Active Shooter – Location – Run, Hide, Fight
- Person with a Weapon – Location
- Missing Infant – Location
- Missing Child – Location
- Missing Adult – Location
- Bomb Threat – Location – Follow security instructions
- Combative Person – Location

Medical Alerts

- Stroke Patient – Location
- STEMI Patient – Location
- Pediatric Emergency – Location
- Rapid Medical Response – Location

Code Blue (Exception)

- Code Blue – Location*

* Code Blue remains the sole exception to the plain language emergency alert initiative and will continue to be announced and managed as traditionally used due to its universal recognition in healthcare and integration into clinical response systems and workflows.

2. Terminating an Emergency Alert

- A. Once the emergency has been effectively managed or resolved, and in accordance with the EOP, the emergency alert should be canceled. An “all clear” notification should be communicated to all individuals who received the initial notification.

Recommended announcement: “All clear. The emergency event has been resolved. All clear.” Repeat according to organizational policy.

- B. The cancellation notification should be communicated using the same process used to activate the initial alert whenever possible. For example, if an overhead paging system was used to activate the alert, the overhead paging system should be used to communicate the all clear.

3. Providing Competency-based Staff Education

Competency-based education regarding plain language emergency alerts should be provided to all employees during orientation and reviewed during annual life safety and emergency preparedness education. Physicians, contracted personnel, volunteers and public safety and security personnel should also receive education as appropriate.

Education should include:

- A. The three categories used to organize emergency events: Hospital Alerts, Medical Alerts, Security Alerts
- B. The purpose and benefits of standardized plain language emergency alerts.
- C. The organization’s process for emergency alert activation and notification in accordance with the EOP.
- D. When instructions should be included in overhead announcements.
- E. The Code Blue exception and its continued use.
- F. Specific responsibilities based on job duties and assigned roles within the EOP.

APPENDIX C

SAMPLE FAQs

Why is HASC endorsing and leading an initiative to adopt standardized plain language emergency alerts?

Healthcare facilities are committed to increasing patient/resident, employee and visitor safety during an incident. The need to standardize emergency alerts has been recognized by healthcare emergency management and patient safety staff. The decision to adopt plain language was proactive and based on literature research, federal initiatives and early trends among healthcare facilities to promote transparency and safety.

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 does the recommendation eliminate all color codes?

The HASC Emergency alerts Workgroup felt that mixing color codes and plain language alerts could create confusion and undermine the goal of using communication that is immediately understood. Therefore, hospitals transitioning to plain language are encouraged to retire legacy color codes. Code Blue is the only exception and will be retained because it is universally recognized in healthcare and deeply embedded in clinical response processes and systems.

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

Although this concern is commonly expressed, research suggests that plain language does not create additional fear among patients and visitors. In fact, it may decrease uncertainty among patients and visitors. To address the growing concern of patient and family confusion, a recent Joint Commission report on health literacy and patient safety recommends making plain language a “universal precaution” in all patient encounters. Studies include the 2005 Anthony R. Mawson article [Understand mass panic and other collective responses to threat disaster].

Does use of plain language reduce patient/resident privacy or protection?

If policy implementation adheres to principles of privacy and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security and Breach Notification Rules, the use of plain language should not adversely affect patient/resident privacy.

How should a hospital determine which emergency alerts to announce to all patients, visitors and employees and which emergency alerts 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 alerts that at least the majority of patients, employees, physicians, visitors and the public should be aware of and prepared to act on.

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. All persons who are at immediate risk of serious injury or death need to be told of that risk and given the opportunity to take protective actions.

Is it acceptable to reduce noise by not using overhead pages?

Some hospitals have moved toward reducing noise for patients by minimizing overhead paging and communicating emergency situations through other means. This move is received well by patients, families and staff. Each hospital will need to determine which emergency situations need to reach the patient's awareness. Some emergencies may be communicated through other means to the appropriate staff that need to respond. As a general rule, the trend is to reduce the amount of overhead paging and announce only those alerts that at least the majority of patients, employees and visitors should be aware of and prepared to act on.

APPENDIX D

REFERENCES

1. Bayea, S.C. Noise: a distraction, interruption, and safety hazard [patient Safety First]. AORN J. 2007;86(2):281- 285. <https://aornjournal.onlinelibrary.wiley.com/doi/10.1016/j.aorn.2007.07.017>
2. California Department of Public Health (CDPH). (n.d.). California public health and medical emergency operations manual [PDF]. https://www.cdph.ca.gov/Programs/EPO/CDPH%20Document%20Library/EOM%20Documents/California_Public_Health_and_Medical_Emergency_Operations_Manual-current.pdf
3. Centers for Medicare & Medicaid Services (CMS). (n.d.). Emergency preparedness rule. <https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-emergency-preparedness/emergency-preparedness-rule>
4. Centers for Medicare & Medicaid Services (CMS). (n.d.). National provider communication standards [PDF]. <https://www.cms.gov/files/document/national-provider-communication-standards.pdf>
5. Committee HT/13, Hospital Emergency Procedures. (1997). Australian Standard® AS 4083-1997: Planning for emergencies-Health care facilities. Retrieved from the SAi Global website: <https://www.australiastandards.com/product/as-4083-1997/>
6. Dezechache, G. (2015). Human collective reactions to threat. WIREs Cognitive Science, 6(3), 209-219. doi:10.1002/wcs.1344
7. Drury, J., Novelli, D., Stott, C. (2013). Psychological disaster myths in the perception and management of mass emergencies. Journal of Applied Social Psychology, 43(11), 2259-2270. doi:10.1111/jasp.12176
8. Dyble, J. (2011). Ministry of Health Services Policy Communique: Standardized hospital colour codes. Retrieved from the Government of British Columbia website: <https://www2.gov.bc.ca/assets/gov/health/keeping-bc-healthy-safe/health-emergency-response/standardized-hospital-colour-codes.pdf?bcgovtm=buffer>
9. Emergency Nurses Association (2016). Plain Language Emergency Alerts Position Statement. <https://www.ena.org/sites/default/files/2025-08/Plain%20Language%20Emergency%20Alerts%20Position%20Statement.pdf>
10. Hipple, S.F. (2010). Multiple jobholding during the 2000s. Monthly Labor Review. Retrieved from the U.S. Bureau of Labor Statistics website: <http://www.bls.gov/opub/mlr/2010/07/art3full.pdf>
11. Hsu, T., Ryherd, E. E., Persson Waye, K., & Ackerman, J. (2012). Noise pollution in hospitals: Impact on patients. Journal of Clinical Outcomes Management, 19(7), 301-309
12. Institute of Medicine (2004). Health literacy: a prescription to end confusion. ISBN. 0-309-09117-9.
13. International Association of Fire Chiefs. (2009). Position statement: “Plain language” use in radio communications. Retrieved from: <https://www.iafc.org/about-iafc/positions/position/iafc-position-plain-language-use-in-radio-communications>
14. Johnson, P. R., & Thornhill, L. (2006). Noise reduction in the hospital setting. Journal of Nursing Care Quality, 21(4), 295-297. <https://doi.org/10.1097/00001786-200610000-00003>
15. Joint Commission Resources (2012), Emergency management in health care: an all hazards approach (2nd ed). ISBN: 978-1-59940-701-2.
16. Konkani, A., Oakley, B., Penprase, B. (2014). Reducing hospital ICU noise: A behavior-based approach. Journal of Healthcare Engineering, 5(2), 229-246. doi:10.1260/2040-2295.5.2.229
17. Li, S.Y., Magrabi, F., Coiera, E.J. Am Med Inform Assoc. 2011 Sep 23. A systematic review of the psychological literature on interruption and its patient safety implications. <https://psnet.ahrq.gov/issue/systematic-review-psychological-literature-interruption-and-its-patient-safety-implications>
18. MacKenzie, D. J., & Galbrun, L. G. (2007). Noise levels and noise sources in acute care hospital wards. Building Services Engineering Research and Technology, 28(2), 117-131. <https://doi.org/10.1177/0143624406074468>
19. Mapp, A., Goldsack, J., Carandang, L., Buehler, J.W., Sonnad, S.S. (2015). Emergency codes: A study of hospital attitudes and practices. Journal of Healthcare Protection Management, 31(2), 36-47.
20. Mawson, A. (2005). Understanding mass panic and other collective responses to threat and disaster. Psychiatry: Interpersonal and Biological Processes, 68(2), 95-113. doi:10.1521/psyc.2005.68.2.95

21. Minnesota Hospital Association (n.d.) Plain language emergency overhead paging: implementation toolkit. <https://www.mnhospitals.org/wp-content/uploads/Portals/Documents/ptsafety/overhead-paging-toolkit-2011.pdf>
22. Moore, M. M., Nguyen, D., Nolan, S. P., Robinson, S. P., Ryals, B., Imbrie, J. Z., & Spotnitz, W. (1998). Interventions to reduce decibel levels on patient care units. *The American Surgeon*, 64(9), 894-899. PMID: 9731822
23. National Fire Protection Association (2012) Life Safety Code 101. <https://www.nfpa.org/for-professionals/codes-and-standards/list-of-codes-and-standards/free-access>
24. Padilla-Elfas, N., Pena-Orellana, M., Rivera-Gutierrez, R., Gonzalez-Sanchez, J.A., Centeno, H.A.M., Alonso-Serra, H., ... Monserrate-Vazquez, P. (2013). Diversity of emergency codes in hospitals. *International Journal of Clinical Medicine*, 4(4), 499-503.doi:10.4236/ijcm.2013.411088
25. Pennsylvania Patient Safety Authority. (2015). Standardized Emergency Codes May Minimize “Code Confusion.” *Pennsylvania Patient Safety Advisory*, 12(1), 1-6. https://patientsafety.pa.gov/ADVISORIES/Pages/201503_01.aspx
26. Plain Language Action and Information Network (PLAIN) information on education and regulations for plain language. <https://www.plainlanguage.gov/>
27. Porth, L. (2013) MHA Standardized, Plain-language Emergency Codes: Implementation Guide. Missouri Hospital Association. Available at https://www.mhanet.com/mhaimages/SQL/EmergencyManagement/Standardized.%20Plain%20Language%20Emergency%20Codes_Implementation%20Guide_0413.pdf
28. Proulx, G., Sime, J.D. (1991). To prevent ‘panic’ in an underground emergency: Why not tell people the truth? *Fire Safety Science-Proceedings of the Third International Symposium*, 843-852. doi:10.3801/ IAFSS.FSS.3-843
29. Redish, J. C. (2000). What is information design? *Technical Communication*, 47(2), 163-166.
30. Stokowski, L.A. The inhospitable hospital: no peace, no quiet. *Medscape Today*. <https://www.medscape.com/viewarticle/574813> (login required)
31. Sweeney, C. (2015, July 13). When It Comes to Hospital Shootings, Emergency Color Codes Don’t Work. *Boston Magazine*. Retrieved from: <https://www.bostonmagazine.com/2015/07/13/hospital-shootings-emergency-color-codes/>
32. The Hospital Incident Command System (HICS) Guidebook, accessible via the Internet (requires login) at <https://emsa.ca.gov/hics/>
33. The Joint Commission. (2022). R3 Report: New and revised emergency management standards. <https://digitalassets.jointcommission.org/api/public/content/e28194d90fe04da8afca5035e77f54d3?v=b53316da>
34. The Joint Commission. (n.d.). Emergency management resource center. <https://www.jointcommission.org/en-us/knowledge-library/emergency-management>
35. Truesdell, A. (2005). Meeting hospital needs for standardized emergency codes - the HASC response. *Journal of Healthcare Protection Management*, 21(1), 77-89.
36. U.S. Department of Homeland Security (2008) National incident management system. https://www.fema.gov/sites/default/files/2020-07/fema_nims_doctrine-2017.pdf
37. Proulx, G., & Sime, J. D. (1991). To Prevent ‘Panic’ in an Underground Emergency: Why Not Tell People the Truth? *Fire Safety Science*, 3, 843-852. <https://doi.org/10.3801/IAFSS.FSS.3-843>
38. Perry, R. W., & Lindell, M. K. (2003). Preparedness for emergency response: Guidelines for the emergency planning process. *Disasters*, 27(4), 336-350. <https://doi.org/10.1111/j.0361-3666.2003.00237.x>
39. Flesch, R. (1948). *The art of readable writing*. Harper & Row.



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VISION

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CONTACT

Teri Hollingsworth, MAM

Vice President of HR and Education Services
Hospital Association of Southern California
thollingsworth@hasc.org



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