



Fire & Life Safety Practices

Ambulatory Surgical Centers

2013

Forward

On January 10, 2003, the Centers for Medicare and Medicaid Services (CMS) published final rules in the Federal Register adopting the 2000 edition of NFPA 101, Life Safety Code (LSC). This final rule amended the fire safety standards for certified facilities. Further, this final rule adopted the 2000 edition of the LSC and eliminated references to all earlier editions. These regulations were effective on September 11, 2003. For new construction, remodels and renovations, facilities are to use the 2012 NFPA 101 LSC for plan review as allowed by Section 1.5.1 of the 2000 LSC.

This manual is designed to assist facilities in meeting minimum code requirements for fire and life safety topics for the benefit of patients and employees. It is intended to provide guidance to facilities, but is not necessarily fully inclusive of all details of federal, state and local requirements. Determinations of compliance with LSC regulations are made at the time of survey.

It is the goal of the Office of State Fire Marshal (OSFM) to partner with the Ambulatory Surgical Centers (ASC's) and End Stage Renal Dialysis (ESRD's), in working together to maintain a safe facility. We hope to foster an open dialogue with facilities so that questions pertaining to the fire and life safety code requirements are asked and answered prior to any final decisions being made. This should prevent any unnecessary hardships on the facility and ensure compliance with the codes.

Scope

All ASC / ESRD'S in Oregon are mandated to comply with state fire and life safety requirements as specified in the Oregon Fire Code (OFC), the Oregon Structural Specialty Code (OSSC), i.e. the state building code, & the Oregon Mechanical Specialty Code (OMSC). In addition, all health care facilities certified by Centers for Medicare & Medicaid Services (CMS) are mandated to comply with the NFPA 101 Life Safety Code (LSC), 2000 Edition (adopted 2003).

Enforcement of Regulations

The enforcement of Fire & Life Safety regulations in health care facilities is for the purpose of ensuring occupant safety. The safety of all occupants is paramount, and the rights of an individual shall not supersede the rights to personal safety of other occupants. For the purposes of this section occupants shall be defined to include patients, staff members, family members, and other persons within the facility.

§ 42CFR 483.75 (b) Administration... Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

Oregon State Statutes and Rules Authorizing Deputies to Enforce Codes

- ORS Ch. 441- Licensing & supervision of facilities & organizations
- ORS 441.015- Licensing of facilities and health maintenance organizations
- ORS 476.030- Authorizes adoption of the Oregon Fire Code
- ORS 476.150- Authorizes entry and inspection of authorized premises
- ORS 479.215- Institutional licensing & compliance with life safety codes
- ORS 479.170- Repair of building & dangerous conditions
- OAR 837, Div. 40- Fire & life safety regulations

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INTRODUCTION FIRE & LIFE SAFETY

Except as otherwise noted, the plans and forms shown in this manual are intended to serve as guides that healthcare facilities can use to help ensure compliance with applicable codes and standards and minimize the risk of being issued deficiencies during a federal life safety certification survey. It is important that the facility's plans and forms include the information necessary to demonstrate full compliance with applicable codes and standards.

Applicable Codes

In order to meet federal Medicare/Medicaid certification requirements, healthcare facilities must be in compliance with National Fire Protection Association (NFPA) Standard 101, *Life Safety Code*®, 2000 edition. In order to meet state licensure requirements, healthcare facilities must be in compliance with the 2010 *Oregon Fire Code* (OFC). Compliance with state licensure requirements is also a condition of federal Medicare/Medicaid certification.

NEW vs. EXISTING for purposes of federal certification:

- Buildings constructed, or for which plans were reviewed, or a permit issued prior to March 11, 2003 are considered EXISTING buildings and must comply with NFPA 101(2000) Chapter 21.
- Buildings, or portions of constructed, or for which plans were reviewed, or a permit issued on or after March 11, 2003 are considered NEW and must comply with NFPA 101(2000) Chapter 20 (this would include additions to and/or major renovations of existing buildings/facilities)

Documentation – The Basics

Both NFPA 101(2000) and the 2010 OFC require that a fire safety and evacuation plan be prepared and maintained for healthcare occupancies. The codes expect that all employees will receive on-going training with respect to their duties under this plan. In addition, a plan must be in place detailing how a facility will handle situations in which the building fire sprinkler system and/or fire alarm system are out of service. The codes also contain requirements relating to the flame resistance of drapes, curtains and decorations, the flame spread rating of interior finishes and, by reference to other NFPA standards, the testing, inspection and maintenance of fire protection systems. In order to receive credit during a fire/life safety survey, it's not enough just to have the required plans, the plans must contain, at a minimum, all the information specified in the codes. Everything must be properly documented and accessible – if it isn't documented, it didn't happen.

It is important that however the following documents are organized, that they can be produced at the time of the survey:

- Building information
 - Up-to-date 8½” x 11” floor plan drawings of all levels of the building
 - Date(s) of construction of the original building and any subsequent additions
 - Construction type(s) of the original building and any subsequent additions
- Disaster Manual/Emergency Preparedness Policies
- Fire Drill Documentation
- Fire Watch (Systems Out of Service) Policy and Documentation
- In-Service Training for Staff
- Weekly, Monthly, Quarterly and Annual Fire Alarm System Maintenance
- Weekly, Monthly, Quarterly and Annual Fire Sprinkler System Maintenance (Including an annual forward flow test of the system and 5-year maintenance)
- Monthly and Annual Portable Fire Extinguisher Maintenance and 3 years of previous tags.
- Weekly, Monthly and Annual Generator Maintenance (Including the 3-year, four-hour load bank test)
- Documentation verifying competency training for facility staff performing weekly, monthly and quarterly testing of the sprinkler, alarm and generator systems.
- Smoking Policy (Staff/patients).
- Monthly door inspection reports.
- Monthly and annual emergency light testing.
- Humidity Level Log for anesthetizing locations (30% - 60%).

It is important that documentation is kept in one place as it reduces the likelihood of getting lost or misplaced, which can lead to a federal deficiency. Being organized can also speed up the documentation review portion of your facility’s annual fire/life safety survey. Documentation must be available at all time including off hours, holidays, weekends, etc.

CHAPTER 1 EMERGENCY PREPAREDNESS

Code Reference:

Facilities shall have and maintain a plan for the protection of all persons in the event of fire, or other emergency, which would require either relocation or evacuation. Such plans shall be reviewed or updated annually and more frequently, or as necessitated by changes in staff assignments, occupancy, or the physical arrangement of the building. Copies shall be furnished to the fire code official for review upon request. *OFC Chapter 4; NFPA LSC 101 Section 20/21.7, NFPA 99 Chapter 11.*

ASC / ESRD'S's are expected to maintain services for patients during disasters. Facilities shall develop and be prepared to implement an emergency preparedness plan that will assess, prepare for, respond to, mitigate and recover from disasters. It is important that facilities have an emergency preparedness plan/disaster manual that addresses required topics and is useful to employees in emergency situations.

Goals of Emergency Preparedness:

- Prevention of loss of life.
- Prevention or mitigation of trauma to patients and other occupants.
- Maintenance of hospital services to the greatest extent possible, given the severity of the disaster.
- Prevention or minimization of property loss.

Planning should focus on local emergency situations, such as severe weather topics, hazards related to close proximity of industrial or transportation complexes (HAZMAT release incidents), or earthquake possibilities due to local seismic activity. Planning for these events should include the capacity of the ASC / ESRD'S to provide services during such an emergency. There is no way to plan for all possible emergencies, but by focusing on logical events and operating capacity thresholds, the ASC / ESRD'S can develop a useful plan as well as a guideline for staff to operate within that plan.

The first step in developing an emergency plan is to conduct an analysis of potential local hazards that could create a need to activate the plan. Sometimes referred to as a hazard vulnerability assessment, the following items should be considered when developing a list of possible hazards:

Natural Disasters, such as: High Wind Events (Tornados), Severe Thunderstorms, Snow or Ice Storms, Earthquakes, Wildfires, Landslides, Volcanoes, Tsunamis, etc.

Human Events, such as: Internal Building Fire, Mass Casualty Incident, External HAZMAT Exposure, Biological or Chemical Terrorism, Hostage Situation, Labor Action, Internal Flood, Internal HAZMAT Exposure, Bomb Threat, etc. (This would be where a facility would include a fire plan).

Technological Events, such as: Communications Failure, Electrical Failure, Generator Failure, Water Failure, Fire Alarm Failure, Med Gas Failure, etc.

It is recommended that facility employees responsible for emergency planning and hazard vulnerability assessment contact their local (city or county) emergency manager for information on local hazards. These agencies are a great resource for information on creating an applicable plan.

Following the hazard vulnerability assessment, develop a written plan for responding to all identified hazards. Since each nursing home/hospice may not have the same set of problems or resources, each plan will be tailored to each facility's hazard vulnerability assessment results. A hazard vulnerability assessment and review of the plan shall occur annually.

To assist facilities with evaluating the compliance of their emergency preparedness plans, a check list has been included in this manual. See Appendix F for a comprehensive check list which covers all requirements of federal (CMS/CFR) and state (OSFM/OFC) regulations. For an electronic version of this check list refer to OSFM website.

http://www.oregon.gov/OSP/SFM/FLSS_EPPChecklist.shtml

To learn more about the Incident Command System and how to integrate it into your emergency disaster plan, go to <http://training.fema.gov/EMIWeb/IS/is100HCb.asp> . There is a class specific to healthcare agencies called *IS-100.HCb - Introduction to the Incident Command System (ICS 100) for Healthcare/Hospitals*

Specific Topics

All disaster plans should address issues regarding internal fires, staffing shortages, bomb threats, lost patients, plans for functioning independently for 96 hours, and total evacuation of the facility. The hazard vulnerability assessment will indicate what shall be included in the required topics of your facility's plan.

Plan availability

It's extremely important that staff have immediate access to the facility's disaster plan in case of an emergency. A complete copy of the plan, including floor plan drawings, should be kept at an accessible location, such as each nurse station. The floor plan drawings shall show, at a minimum, the location of emergency exits, smoke barriers and the location of the main utility shut-offs (water, gas and electricity). This book is intended as a quick reference in the event of an emergency. Place items such as fire drill policies and procedures in an employee handbook or other designated book.

CHAPTER 2 PROCEDURES IN CASE OF FIRE

Code Reference:

For ASC / ESRD'S, the proper protection of patients requires the prompt and effective response of health care staff. The basic response required of staff includes; removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients. *NFPA 101 Sections 20/21.7.2*

The following components shall be included in a facility's fire response plan:

1. Upon discovery of a fire, staff shall immediately take the following action:
 - a. If any patient becomes directly involved in a fire, the staff member who discovers this situation shall go to the immediate aid of that patient, while calling aloud Code Red and where the fire is located (i.e. "Code red, room 3"). **NOTE: The use of a code phrase provides for both the immediate aid of any endangered person(s) and the transmission of an alarm without causing panic amongst the patients.** Any staff member in the area, upon hearing the code called aloud, shall activate the building fire alarm using the nearest manual fire alarm box.
 - b. If a patient is not directly involved in a fire, the staff member who discovers this situation shall isolate the fire, if possible, and activate the building fire alarm using the nearest manual fire alarm box.
 - c. Staff, upon hearing the fire alarm signal, shall immediately perform their duties as assigned in the facility fire safety plan. It is especially important to ensure that staff is trained on a command structure and that someone is always designated as "in charge" and trained in that role in emergency situations.
 - d. A staff member shall be responsible for locating the fire and promptly notify the staff member responsible for overhead paging and advise them of the specific fire location. An overhead page shall be given with the code phrase and location of the fire three times (i.e., "Code Red, Room 3- Code Red, Room 3- Code Red, Room 3"). This announcement shall be repeated every minute until the smoke compartment or the building has been evacuated.
 - e. Upon report of a fire within the facility, a designated staff member shall immediately dial 911 to confirm the report of a fire and pass on any pertinent information, such as the location of the fire, if anyone is trapped, how many occupants are in the building, etc.
 - f. If the building fire alarm system is out of service, any staff member or person conducting fire watch who discovers a fire shall immediately pull the fire alarm pull station and dial 911 (see fire watch procedures Chapter 6).

2. Procedures to protect the lives of all patients within a facility involves five basic steps for fire emergencies. The term R.A.C.E.R. is an easy way to remember the five basic steps. **NOTE: *These five steps must be accomplished to successfully deal with a fire emergency. The order they are performed will vary according to the circumstances.***

Rescue- Rescue patients in immediate danger if safe for staff to do so. These actions include assessing the fire, as well as moving patient(s) in nearby rooms away from immediate danger.

Alarm- Activate the fire alarm system. This includes calling “Code Red” and activating a manual fire alarm box.

Confine- Confine the fire to the room where the fire started or to the smallest area possible. Normally this is accomplished by closing the door to the room of the fire.

Extinguish- Put the fire out, if possible. Assess the fire to determine if it is small enough to be extinguished through the use of one or two portable fire extinguishers.

Relocate- Relocate all patients from the smoke compartment of the fire into the nearest smoke compartment, exit enclosure, exterior exit, or the exterior of the building (non-sprinklered facilities). Move from there as necessary. Do not take patients past the room of origin when relocating. Take an outside route if necessary.

3. Non-Sprinklered Facility...Procedures to protect the lives of all patients within a **non-sprinklered facility** requires the prompt and effective response of personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area and the relocation of all patients to the exterior of the building to a predetermined place as detailed in the facility’s fire safety plan. (See Chapter 3 for a step-by-step process)

4. Emergency Incident Command

- a. Until the fire department arrives, the facility charge person is responsible to oversee and manage the emergency and make emergency staff assignments, which may include the following, depending on the nature of the emergency:

(1) Send assistance immediately to the fire area.

(2) Assign others to assist in relocating all patients in the fire area to a point beyond the nearest smoke barrier doors. **NOTE: *This is the minimum acceptable level of occupant protection required by the Defend in Place concept.***

The priority for relocation of patients from within the affected smoke compartment is:

- (a) First, patients who require staff directions and/or verbal prompting only.

- (b) Second, patients that require limited staff physical assistance (i.e. transfers).
 - (c) Third, patients that require full physical assistance by staff or are restricted to beds or gurneys.
- (3) Close and mark doors of evacuated rooms (using tape, chalk, door hangars, magnets, etc.), do not place items at the base of the doors in the corridor.
 - (4) Assign person(s) to clear hallways of food carts, housekeeping equipment, etc., so there will be clear access for fire equipment or for evacuation.
 - (5) Send a person outside to meet fire department personnel and direct them to the location of the fire.
 - (6) Assign supervision of those patients requiring special attention or services, such as wandering, confused, non-alert, or intellectually disabled patients. Make sure to account for all occupants moved or missing and report to the fire department.
- b. Upon arrival of the fire department, the senior fire authority (Incident Commander) and the facility charge person shall coordinate their actions to ensure patient safety.

NOTE: *If it is deemed necessary to evacuate patients to a temporary evacuation site or a long-term location, the Office of State Fire Marshal shall be immediately notified at 503-934-8202 or 503-329-1651.*

**** Under no circumstances shall a facility cancel a fire department response. An all-clear signal shall only be given after confirmation from the fire department that an alarm signal was false. If the alarm was the result of a system malfunction, the facility shall begin fire watch until the issue is resolved (See Chapter 6 for procedures). If the signal was the result of a patient activating a manual pull station falsely, consult the fire code official for possible solutions.**

CHAPTER 3 RELOCATION & EVACUATION PLAN

Code Reference:

Copies of a fire safety and evacuation plan shall be readily available in the work place for reference and review by supervisors and staff including at constantly attended locations, such as a nurse's station. Copies of the plan shall be furnished to the fire code official upon request. *Based on NFPA 101 Chapter 20/21.7.2 and NFPA 99 Chapter 11.*

1. Based upon a coordinated decision between the Incident Commander and facility charge person, the entire facility may need to be evacuated.
 - a. The complete evacuation procedure shall include, but not limited to, the following considerations:
 - (1) A designated person who has the authority to order evacuation (i.e., charge person, administrator, incident commander, etc.).
 - (2) The order in which the patients will be moved, based on mobility.
 - (3) An outline for triage within the facility and outside the facility prior to transportation to evacuation center.
 - (4) Designated external staging area(s) where patients will be taken on a short-term (96-hour) basis pending return to facility or further transfers.
 - (5) Designated temporary shelter(s) where patients can be housed pending long-term relocation, if circumstances prevent return to the facility in a short-term period.
 - (6) Records (medical and personal information) shall be moved with the patient.
 - (7) What equipment and supplies must accompany the patients?
 - (8) Designated staff to remain with the evacuated patients.
 - (9) Designated long-term (over 96-hours) relocation site(s) shall be pre-identified to provide on-going patient care.
 - (a) A current signed letter of agreement between the facility and relocation site(s) shall be on file at the facility. Agreements shall be reviewed and updated not less than every 12 months. An update date may be documented if the agreement is reviewed verbally. Continuing open-ended agreements are prohibited.
 - (b) Facilities which choose to use long-term relocation sites that are within the same corporation and of equal licensing shall have written policies in lieu of signed letters of agreement.

- (10) If there are financial issues related to transfer to another facility, identify who has the authority to negotiate payment.
- (11) Identify means of transportation of patients to the evacuation center(s).
 - (a) A current signed letter of agreement between a facility and at least two transportation companies shall be on file at the facility. Agreements shall be reviewed and updated as necessary, not less than every 12 months. Continuing open-ended agreements are prohibited.
 - (b) Facilities which have their own transportation vehicles shall have written policies in lieu of a signed letter of agreement with one company. The policy shall include the location of the key and vehicle, and contact information for drivers. A secondary letter of agreement shall be made with an outside company to prepare for possible vehicle failures.
- b. The complete evacuation of the facility would require a step-by-step process of moving patients through a series of temporary safe areas.
 - (1) **External Staging Area...**Designated staging areas outdoors away from the facility to get people away from the hazard as quickly as possible.
 - (2) **Temporary Evacuation Sites...**Should be designated near the facility so that patients can be housed out of the elements during the time needed to analyze long-term options. Written agreements shall exist for temporary use of nearby schools, churches, or other buildings.
 - (a) Criteria for Temporary Shelter:
 - 1) Length of stay not to exceed 96 hours.
 - 2) Shall maintain a “reasonable” degree of fire and life safety.
 - 3) Building is not required to have fire sprinklers or fire alarm system.
 - 4) Map of building indicating placement of materials and patients.
 - (3) **Long-Term Evacuation Sites...**Should be pre-identified site(s) to provide on-going patient care. Options may include: transfer to another facility, release to family members, or mass care in designated shelters. Written agreements should exist for long-term use of pre-designated sites.
 - (a) Criteria for Long-Term Site:
 - 1) Length of stay could exceed 96 hours to an unspecified period of time.
 - 2) Fire & life safety needs of the patients shall be met.
 - 3) Built-in fire protection shall be required along with the capability to serve critical care patients (i.e., fire sprinklers & fire suppression systems).
 - 4) Before identifying a long-term relocation site, consider possible area wide catastrophic events (i.e., earthquake, volcanic eruption, flood). Consider agreements with facilities within 50-miles and outside of 50-miles.
 - 5) Shall maintain an equivalent level of care (Nursing home or hospital).

4. Evacuation Site Evaluation

- a. The facility administrator or designee shall conduct an assessment of all staging and evacuation sites. Floor plans and operational diagrams (where to place patients, records, medications, food, etc.) shall be attached to the signed relocation agreements specified above.
- b. Based upon the facility emergency preparedness plan, the letter of agreement between the facility and the evacuation site shall identify whether such site meets the temporary and/or long-term evacuation site criteria.

CHAPTER 4 FIRE/EVACUATION DRILLS

Code Reference:

Emergency evacuation drills shall be conducted quarterly on each shift to familiarize facility staff with the signals and emergency action required under varied conditions. *OFC Section 405; NFPA LSC 101 Section 20/21.7.1.*

ASC / ESRD patients have, in large part, varied degrees of physical disability. Their removal from the facility or even a disturbance caused by moving is impractical in many cases, except as a last resort. Fire and evacuation drills are a way for staff to familiarize themselves with the smoke compartments of the building and to simulate varying emergency conditions without causing distress to the patients.

1. Fire drills in ASC / ESRD'S include the transmission of a fire alarm signal and simulation of emergency fire conditions. Audible signals shall be given between 6 am and 9 pm; (If the alarm system is Private Mode (chime strobe), the audible alarm may be sounded at any time. Private mode fire alarm systems are appropriate for healthcare facilities and are intended to reduce the panic of patients and allow staff to communicate more clearly. These systems are required by OSFM in all new installations or major remodels).
 - a. Fire drills shall not be considered as employee in-service training.
2. Many facilities conduct fire drills without disturbing patients by choosing the location of the simulated emergency in advance and by closing the doors to patient rooms in the vicinity prior to initiation of the drill.
 - a. The purpose of a fire drill is to test and evaluate the efficiency, knowledge, and response of staff in implementing the facility's fire emergency plan.
 - b. Fire drills shall be scheduled at varying days and times throughout shifts to ensure that staff is prepared for many situations. (Some facilities conduct one drill per month and rotate shifts to accomplish this requirement). Drills shall consider the ability to move patients to an adjacent smoke compartment or to the exterior of the building. Relocation can be practiced using simulated patients, staff giving a verbal description of their actions, or by moving empty wheelchairs/gurneys.
3. Administrative responsibilities for conducting fire/evacuation drills.
 - a. All staff shall be instructed in the use of and response to fire alarms.
 - b. Staff shall be instructed in the use of "Code Red" to ensure transmission of an alarm.
 - c. Responsibility for the planning and conducting of drills shall be assigned to competent persons designated to exercise leadership. The person in charge on each shift shall be included in the drill.

- d. Records shall be maintained of required fire/evacuation drills and include the following information:
 - (1) Date and time of the drill.
 - (2) Shift (Day, Swing, NOC)
 - (3) Number of occupants “relocated” from the affected smoke compartment or to the exterior of the building.
 - (4) Time to complete simulated relocation/evacuation.
 - (5) Notification method used (audible or coded signal).
 - (6) Weather conditions.
 - (7) Problems noted with the building (pull station did not work, door did not close, etc.).
 - (7) Specific Type of Incident Simulated (Trash can fire, bed fire, Kitchen fire, etc.)
 - (8) Location of Incident (Room 3, Laundry Room, D-Wing Hall, etc.)
 - (9) Comments on Staff Performance (Forgot to pull alarm, forgot to shut/mark doors, etc.- Items to review during in-service)
 - (10) Staff members on duty and participating. (It is recommended that facilities include a list of employees and have each participant sign next to their name for accountability and tracking).
 - e. All patients and other building occupants shall be accounted for during fire/evacuation drills.
4. Fire drill/evacuation procedures.
- a. Fire drill procedures are the same as for a real fire and are outlined in Chapter 2 **PROCEDURES IN CASE OF FIRE (R.A.C.E.R.)**.
 - c. Fire drills shall be held at unexpected times and on a random basis. Fire drills shall be conducted under varying circumstances, simulating actual fire conditions.
 - d. The person conducting the fire drill shall notify the fire alarm monitoring company **PRIOR** to the fire drill and again at **COMPLETION** of the fire drill (Test mode).
 - e. An emergency situation shall be simulated - a symbol of a fire (cloth, sign, etc.) with written description of fire problem placed at a predetermined location, a smoke detector or water flow switch activated, etc.
 - f. Emphasize orderly action under proper discipline, rather than speed.

- g. Drills shall include transmission of fire alarm signals throughout the facility. To avoid disturbing patients, drills conducted between 9 p.m. and 6 a.m. may use a coded announcement instead of an audible alarm. **NOTE: *It is recommended that at least one fire drill annually is conducted during these times using the audible fire alarm signal.***
- h. Drills shall include simulation of emergency fire conditions except that the movement of patients to safe areas or to the exterior of the building is not required. However, in order for fire drills to follow required procedures the facility shall *simulate* the evacuation of patients to adjacent smoke compartments or to the exterior of the building. **NOTE: *Patients who are mobile should be removed from involved zones to avoid injury.*** Visitors within the facility also need to be relocated to other zones or exterior of the building, as appropriate.
- i. Written procedures shall require that all staff members participate during fire drills in accordance with emergency preparedness plan. Testing and fire drills require separate documentation.
- j. It is suggested that fire drills be held in conjunction with other required fire alarm tests. For example, testing a smoke detector or fire alarm pull station could serve as both the test and the fire drill.

***** False alarms and actual fires shall not be counted as fire drills. *****

CHAPTER 5

STAFF IN-SERVICE TRAINING PROCEDURES

Code Reference:

All staff shall receive emergency preparedness training as part of new employee orientation and at least annually thereafter. *OFC Section 406; NFPA LSC 101 Sections 20/21.7.2.3 & 20/21.1.3, NFPA 99 Ch. 11.*

Facility administration shall implement a staff training program. This program shall include an overview of the components of the facility's emergency preparedness plan, including concepts of the incident command system.

1. Education concerning the staff's specific duties and responsibilities shall be conducted as follows:
 - a. **Prior to reporting** to their newly assigned departments or positions, staff shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of "Code Red" to ensure transmission of a fire alarm.
 - b. **Within thirty days** of hire, staff shall be trained in fire prevention, evacuation, and fire safety, including the fire emergency procedures described in the facility's fire evacuation and fire safety plans.
 - c. **Not less than once each year**, all staff shall be required to demonstrate competence in the subject content areas listed in Section 4 of this chapter.
2. All in-service training shall be documented on approved forms and a roster kept of employees who received training.
3. Determination of Staff Competence
 - a. Staff training programs shall be designed to meet the listed competencies below.
 - b. Facilities shall have policies regarding staff attendance and compliance with the listed competency areas.
 - c. Staff shall receive sufficient training to be capable of meeting the subject content in the manner listed in the competencies.
4. **Fire & Life Safety Competencies**
 - a. Fire Prevention
 - (1) Staff shall be instructed in procedures for preventing fires in the conduct of the assigned duties.
 - (2) Staff shall identify at least three common types of ignition sources that cause fires, and describe several places where they are likely to be found.

b. Evacuation Training

- (1) Staff shall be familiar with the fire alarm signals, their assigned duties in the event of an alarm or emergency, relocation/evacuation routes, areas of refuge, exterior assembly areas, and procedures for evacuation.
- (2) Staff shall explain why they need to participate in fire drills.
- (3) Staff shall understand the properties of smoke and describe its dangerous affects.
- (4) Staff shall list and describe fire safety features of the facility and their proper use (i.e., fire sprinklers, fire alarms & detection, doors, smoke compartments, etc.).
- (5) Staff shall describe the emergency relocation and evacuation plan for the facility.
- (6) Staff shall list the five basic steps for “R.A.C.E.R.” and explain the procedures of both relocation (defend in place) and complete evacuation of the facility.
- (7) Staff shall describe how to assess fire and smoke conditions prior to approaching a fire to attempt extinguishment or rescue.
- (8) Staff shall describe how to move patients to a safe area of refuge.

c. Fire Suppression

Staff assigned fire-fighting duties shall be trained to know the locations and proper use of portable fire extinguishers or other manual fire-fighting equipment and the protective clothing or equipment required for its safe and proper use.

- (1) Staff shall demonstrate how to extinguish a fire involving a patient.
- (2) Staff shall describe the “PASS” procedure for using a fire extinguisher.

d. Emergency Preparedness (see “Training & Exercising the Emergency Preparedness Plan” worksheet in Appendix A)

- (1) Staff shall describe their responsibilities as outlined in the facility’s emergency preparedness plan.
 - (a) Staff shall be familiar with how the emergency preparedness plan will be activated and terminated.
 - (b) Staff shall demonstrate their duties and assignments as outlined in the facility’s emergency preparedness plan.
- (2) Staff shall describe their position in the facility’s incident command system, including who they report to during an emergency. (“Chain of Command” or organizational chart for the facility)

- (3) Drills for the emergency preparedness plan shall be either rehearsed or a table-top review of a scenario. All portions of the plan shall be exercised annually.
 - (a) At least one drill per year shall rehearse a mass casualty response for health care facilities with emergency services, disaster receiving stations, or both.
- (4) Two of the following actions shall be exercised annually:
 - (a) Elopement/Abduction (*Code Pink/Amber Alert*)
 - (b) Evacuation-Emergency (partial or full) (*Code Black*)
 - (c) Evacuation-Post Emergency (full) (*Code Black*)
 - (d) Building Security (*Code Green*)
 - (e) Building Ventilation (*Code White*)
 - (f) Understaffing
 - (g) Internal Search
 - (h) Infectious Events
 - (i) Outages (*Code White*)
 - (j) Armed Intruder (*Code Silver*)
 - (k) Weather Related (*Code Yellow*)

OSFM has developed a FREE on-line course that can be used for the annual fire education requirement:

OSFM Online In-service training for Healthcare facilities - Admin Alert

http://www.oregon.gov/DHS/spd/provtools/admin_alert/2011/2011-1130-online-lsc-training.pdf

Link to create a FREE account for the online class

http://www.oregon.gov/DHS/spd/provtools/admin_alert/2011/2011-1130-ilearn-new-acct-non-state-employee.pdf

OSFM Online In-service training for Healthcare facilities- Course login

<https://ilearn.oregon.gov/Kview/CustomCodeBehind/base/login/login.aspx>

CHAPTER 6

HANDLING OF EMERGENCY OR ABNORMAL CONDITIONS

Code Reference:

Where any required fire protection system is out of service for more than four hours in a 24-hour period, the fire department and the fire code official shall be notified immediately and the building shall either be evacuated or an approved fire watch shall be provided for all occupants left unprotected by the shut down until the fire protection system has been returned to service. *OFC Section 901.7; NFPA LSC 101 Section 9.6.1.8 & Section 9.7.6.1.*

ASC / ESRD'S rely on multiple fire and life safety features for redundant protection. Whenever conditions within the building do not meet the fundamental fire and life safety requirements specified in state and federal regulations, additional safeguard(s) shall be provided in case any single safeguard becomes ineffective due to inappropriate human actions or system failure.

For the purposes of this section, a fire protection system that is ***out of service*** means that the system or equipment is incapable of operating as designed and installed or in accordance with standards. Examples of out of service conditions include, but are not limited to: inoperable fire alarm system, automatic sprinkler system water supply turned off, etc.

For the purposes of this section, a fire protection system that is in an ***abnormal condition*** means that the system or equipment, even though it may have some limited operational capability, is not capable of providing all required functions, indications or alarms as designed and installed or in accordance with standards. Examples of abnormal conditions include, but are not limited to: trouble or supervisory signals on the fire alarm panel, turning off the water supply to portions of a sprinkler system for normal repair, maintenance, or testing, deactivation of the transmission of alarm signals to a monitoring station, etc.

1. **Emergency Conditions...**Whenever any fire protection system or equipment is out of service due to hazardous conditions or a fire emergency, the facility administrator or designee **shall immediately** perform the following actions:
 - a. Enact the facility's emergency response plan.
 - b. Notify the local fire department.
 - c. Implement fire watch and/or *interim life safety measures (ILSM)* as required.
 - d. Once items 1.a. through c. have been completed, immediately contact the Office of State Fire Marshal (OSFM) - Healthcare Unit at 503-934-8202. The OSFM is responsible for investigating all emergencies pertaining to institutional occupancies. **It shall be the responsibility of the facility's administrator or designee to consult directly with the OSFM for the purpose of response to the facility, clean-up and restoration of the facility prior to his/her arrival, etc.** If unable to directly contact the Healthcare Unit, call the Duty Officer at 503-931-5732, and provide the name of the facility, location, and nature of emergency condition.

2. **Non-Emergency Conditions...**Whenever required fire protection systems that are out of service for four or more hours in a 24-hour period, the OSFM- Healthcare Unit shall be notified. The building shall either be evacuated or an approved fire watch shall be provided for all occupants left unprotected by the shut down until the fire protection system has been returned to service. In addition, the following shall also be required:
- a. The facility's administrator shall assign an impairment coordinator to comply with the requirements of this section. In the absence of an impairment coordinator, it is the responsibility of the administrator to fill that role.
 - b. A tag shall be used to indicate that a system, or portion thereof, has been removed from service.
 - (1) **The tag shall be posted at each fire department connection, system control valve, fire alarm control unit, security office, communication center, and fire command center, indicating which system, or part thereof, has been removed from service.**
 - c. **Preplanned impairments** shall be authorized by the impairment coordinator. Before authorization is given, a designated individual shall be responsible for verifying that all of the following procedures have been implemented:
 - (1) The extent and expected duration of the impairment have been determined.
 - (2) The areas or buildings involved have been inspected and the risk has been determined.
 - (3) Recommendations have been submitted to facility's administrator or designee.
 - (4) The local fire department has been notified, and OSFM- Healthcare Unit if the impairment lasts more than four hours in a 24-hour period.
 - (5) The supervisors in the areas to be affected have been notified and alerted to all *ILSMs* implemented.
 - (6) A tag impairment system has been implemented.
 - (7) Necessary tools and materials have been assembled on the impairment site.
 - d. When **unplanned impairments** occur, appropriate emergency action shall be taken to minimize potential injury and damage. The impairment coordinator shall implement the steps outlined under "c" above.
 - e. When impaired equipment is **restored to normal working order**, the impairment coordinator shall verify that all of the following procedures have been implemented:
 - (1) Necessary inspections and tests have been conducted to verify that affected systems are operational.

- (2) Supervisors have been advised that protection is restored.
- (3) The local fire department and OSFM - Healthcare Unit has been advised that protection is restored.
- (4) The impairment tag has been removed.

3. Fire Watch

- a. Person(s) who are responsible to conduct fire watches:
 - (1) Shall be provided with at least one approved means for notification of the local fire department, and
 - (2) Their only duty shall be to perform constant patrols of the affected areas of the facility and to keep watch for fires.
- b. When the **fire sprinkler system** is the only inoperable fire protection system, individual(s) assigned fire watch duties shall complete a total walk-through of all affected areas not less than once every **30 minutes**.
- c. When the **fire alarm system** is inoperable, individual(s) assigned fire watch duties shall complete a total walk-through of all affected areas not less than once every **15 minutes**.
- d. Fire watch rounds shall be documented in the facility records, kept on premises for a minimum of three years and available to the fire marshal upon request. Documentation shall be in an approved format.
- e. Fire watch is not required for testing, inspection, and maintenance if less than four hours in a 24-hour period. Exceeding four-hours is considered a lengthy impairment that generally involves a problem more serious in nature than typical system maintenance or testing.
- f. Fire watch in construction areas is not required if the area shut down is not occupied by patients and is separated from the occupied portion of the facility by a two-hour fire wall or a one-hour-rated wall if fire sprinklers remain active during the project.

4. Interim Life Safety Measures...Interim life safety measures (ILSMs) are intended to provide alternative fire protection safe guards when built-in fire safety features are either out of service or have become ineffective. **NOTE: ILSM plan shall be documented in writing and approved by the OSFM Health Care Unit prior to implementation (Ref. OFC Section 404.1). These plans shall also be maintained at the facility and available for review upon request.**

- a. At a minimum, ILSMs shall include the following:
 - (1) Assessment of associated hazards.
 - (2) Equivalent exiting.

- (3) Protection of all occupants from fire and smoke.
 - (4) Fire protections systems and equipment maintained affective or an approved alternative.
 - (5) The construction features of the facility shall be maintained or an approved alternative.
- b. Interim life safety measures that administrators shall address within ILSM plans, include but are not limited to the following:
- (1) Providing additional exits.
 - (2) Installing specialized fire protection.
 - (3) Conducting additional staff training.
 - (4) Providing increased staffing.
 - (5) Building temporary construction and/or fire barriers.
 - (5) Providing additional emergency lighting within the means of egress.
 - (6) Revising of the Hospital's emergency evacuation plans.

**** ILSMs shall be documented in writing, maintained at the facility, and available for review upon request by the Fire Marshal.***

CHAPTER 7

SERVICING OF FIRE PROTECTION SYSTEMS & EQUIPMENT

Code Reference:

It is the responsibility of the facility owner and/or facility occupant to have all fire protection systems and equipment inspected, tested, and maintained in accordance with adopted nationally recognized standards and state regulations. Persons that are qualified, based on competence through training and experience, shall perform all required inspections, testing, and maintenance. Unless on-site staff are trained and qualified, the facility shall have all required inspections, testing, and maintenance performed by a qualified third party service provider. All required maintenance, repairs, and third party services shall be documented. *OFC Section 901; NFPA LSC 101 Section 20/21.7.6.*

1. The following criteria shall be used when determining qualifications of persons who perform inspections, testing, and maintenance of fire protection systems and equipment.
 - a. **Regulations & Standards** – Persons who perform inspections, testing and maintenance of fire protection systems and equipment shall either have copies of or demonstrate their ability to access the regulations and standards specified in this paragraph. (See Page 35 for ordering information.)
 - (1) The Oregon Fire Code, 2010 Edition.
 - (2) Copies of NFPA Standards referenced by the Oregon Fire Code and the Life Safety Code are listed below. Examples of referenced standards most commonly used when performing inspections, testing, and maintenance of fire protections systems and equipment are as follows:
 - (a) 1998 NFPA 10 *Fire Extinguishers*
 - (b) 1998 NFPA 25 *Water Based Fire Protection Systems (Sprinklers, Standpipes, Fire Pumps, etc.)*
 - (c) 1999 NFPA 72 *Fire Alarm Systems*
 - (d) 1999 NFPA 80 *Fire Doors & Other Opening Protectives*
 - (e) 1999 NFPA 99 *Health Care Facilities*
 - (f) 1999 NFPA 110 *Emergency and Standby Generators*
 - (3) If available, manufacturer's instructions for all fire protection systems and equipment to be inspected, tested, and maintained.
 - (4) Other nationally recognized standards (i.e., ANSI, ASME, etc.) that apply to inspections, testing, and maintenance requirements.

- b. **Licenses & Certifications** - Persons who perform inspections, testing, and maintenance of fire protection systems and equipment shall possess and maintain current, all licenses and certifications required by the state of Oregon.

- (1) A copy of required licenses, certifications, etc., shall be kept on their person or on site while conducting inspections, testing, and maintenance of fire protection systems and equipment.

- (2) If required to be licensed and/or hold a permit by a local jurisdiction, provide evidence and maintain documentation of the current license and/or permit on their person or on site.

- (3) All licenses, certifications, etc., shall be available to the fire marshal upon request.

- c. **Technician Competence** – Persons conducting inspections, testing and maintenance of fire protection systems and equipment shall possess documentation of training in regulations and standards specified in “1.a.”. **NOTE: *Examples include training through fire protection systems and equipment manufacturers, NICET, third party service providers, industry associations, NFPA, ICC, etc.***

Individuals shall be required to periodically review all required regulations, standards, manufacturer’s instructions, and any other nationally recognized standards that apply to inspection, testing, and maintenance of fire protection systems. These reviews are for the purpose of ensuring that individuals maintain their knowledge, skills, and abilities regarding technical specifications and procedures.

On a case-by-case basis, the OSFM reserves the right to periodically review an individual’s qualifications and their knowledge, skills, and abilities related to the standards specified in this section.

- 2. If facility administration determines that staff is qualified to perform inspections, testing, and maintenance procedures, they shall comply with the following:

- a. Maintain a list of staff that performs inspections, testing, and maintenance procedures. This list shall be available to the fire marshal upon request.

- b. Maintain an agreement with a third-party service provider. The agreement shall be in effect for emergencies that may exceed the knowledge, skills, and abilities of the qualified facility staff. Such agreements shall be maintained current and valid at all times.

- c. The regulations and standards shall be readily available while individuals are performing inspections, testing, and maintenance of fire protection systems and equipment.

- 3. If facility administration determines that inspection, testing, and maintenance procedures are to be performed by a qualified third party service, the following shall apply:

- a. Copies of agreements shall be maintained current, valid, and on site. Agreements shall be available to the fire marshal upon request.

- b. It is recommended that third party service provider agreements specify the appropriate regulations and standards that will be used for inspections, testing, and maintenance of fire protection systems and equipment
 - c. Facility administration shall be responsible for determining if third party service providers and staff meet the qualifications as outlined in section 1 of this chapter.
4. **Documentation** – Inspection, testing, and maintenance procedures of fire protection systems and equipment, whether performed by facility staff or third party service providers, shall be documented in writing. Documentation shall be available for review to the fire marshal upon request.
- a. Documentation shall be in a format as specified in the regulations and standards as listed in Section 1.a. of this chapter.
 - b. Facilities that use documentation programs or other methods shall include all required information specified within the regulations and standards.

CHAPTER 8

MAINTENANCE, CONSTRUCTION, & REPAIR OPERATIONS

Code Reference:

Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance or otherwise installed, it shall be continuously maintained in accordance with the applicable referenced standards. *OFC Section 107.1; NFPA LSC 101 Section 4.5.7.*

The goal of fire & life safety regulations is to provide an environment for an occupant that is reasonably safe from fire and similar emergencies by the following means:

- Protection of occupants not intimate with the initial fire development.
 - Improvement of the survivability of occupants intimate with the initial fire development.
1. **Occupant Protection...**A structure shall be designed, constructed, and maintained to protect occupants who are not intimate with the initial fire development for the time needed to evacuate or relocate (defend in place).
 2. **Structural Integrity...**Structural integrity shall be maintained for the time needed to evacuate or relocate (defend in place) occupants who are not intimate with the initial fire development.
 3. **Systems Effectiveness...**Systems shall be effective in mitigating the hazard or condition for which they are being used, shall be reliable, shall be maintained to the level at which they were designed to operate, and shall remain operational at all times.
 4. **Maintenance...**All devices, equipment, systems, conditions, arrangements, levels of protection, or other features shall be maintained unless regulations exempt such maintenance. No newly constructed or existing building shall be occupied in whole or in part in violation of the provisions of fire & life safety regulations unless all of the following conditions exist:
 - a. A plan of correction has been approved.
 - b. The occupancy classification remains the same.
 - c. No serious fire and life safety hazard exists as evaluated by the fire code official.
 5. **Construction, Repair, and Improvement Operations**
 - a. Buildings or portions of buildings shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternative life safety measures acceptable to the fire code official are in place.
 - b. In buildings under construction, adequate escape facilities shall be maintained at all times for the use of construction workers. Escape facilities shall consist of doors, walkways,

stairs, ramps, fire escapes, ladders, or other approved means or devices arranged in accordance with the general principles of fire & life safety regulations insofar as they can reasonably be applied to buildings under construction.

- c. Flammable/explosive substance or equipment for repairs/alterations shall be permitted in a building while the building is occupied if the condition of use and safeguards provided do not create any additional danger or impediments to egress beyond the normally permissible conditions in the building.
- d. Equipment requiring periodic testing or operation to ensure its maintenance shall be tested and operated as specified in fire & life safety regulations or as directed by the fire code official.
- e. Maintenance and testing shall be under the supervision of a responsible person who shall ensure that testing and maintenance are provided at specified intervals in accordance with the Oregon Fire Code, applicable NFPA standards, or as directed by the fire code official.
- f. For additions, remodels, and construction related projects also refer to the Construction Project Guide as published by the Department of Human Service.

<http://public.health.oregon.gov/ProviderPartnerResources/HealthcareProvidersFacilities/FacilitiesPlanningSafety/Pages/index.aspx>

OAR 333-675-0000

Submission of Project Plans and Specifications for Review

Any person proposing to make certain alterations or additions to an existing health care facility or to construct new facilities must, before commencing such alteration, addition or new construction, submit plans and specifications to:

Department of Human Services, Public Health Division, Facilities Planning and Safety
880 Winter St. NE
Salem, OR 97301
www.healthoregon.org/fps
(503) 373-7201

This requirement is for plans approval or recommendations with respect to compliance with rules authorized by ORS 441.055, 443.420 and for compliance to National Fire Protection Association standards when the facility is also to be Medicare or Medicaid certified.

CHAPTER 9 DOCUMENTATION

Code Reference:

Documentation shall be in an approved format that clearly indicates all information as required by the standards. Documentation shall provide all information as required by the Oregon Fire Code or specific NFPA Standards. *OFC 405/901.6.2; NFPA 101 Sections 9.6.1.7 & 9.7*

1. Documentation Retention

- a. Documentation of facility-performed inspections and tests, third party inspections, testing and maintenance records of fire protection systems and equipment shall be kept in a permanent file on the premises for the life of the building.
- b. Fire evacuation drills, staff in-service training reports and fire watch logs shall be kept in a permanent file on the premises for a minimum of three (3) years.
- c. All documentation shall be available on site for periodic review by the fire code official upon request.

2. Quality Assurance Review...All required documentation listed in section 1 of this chapter **shall** be reviewed for quality assurance monthly. The purpose of these reviews is to ensure the reliability of fire protection and life safety for the facility.

3. Forms...Publishers, trade associations, etc., have created forms for documenting inspections, testing, and maintenance of fire protection systems and equipment. If these documents are used, be sure that they meet the correct NFPA code edition. Refer to Appendix A for examples of the minimum required documentation acceptable to the Office of State Fire Marshal.

APPENDIX A

SAMPLE DOCUMENTATION

This appendix contains examples of documents for the user's convenience. Alternative documentation that collects equivalent information is acceptable. For fire protection systems and equipment not included on these forms, refer to applicable NFPA standards and manufacturer's guidelines.

1. Fire Protection Systems Inspections Testing and Inspection Logs
3. Fire Drill Records
4. Fire and Life Safety Training/In-service
5. Fire Watch Documentation and Log

FIRE PROTECTION SYSTEMS INSPECTION **(For Inspections Required More Frequently Than Once Each Year)**

The following tests and inspections shall be performed and documented in addition to annual inspection:

Fire Alarm System

1. Inspect the fire alarm in accordance with 1999 NFPA 72, Chapter 7
 - a. Table 7-3.1 Visual Inspection Frequencies
 - b. Table 7-3.2 Testing Frequencies
2. Recommend testing the fire alarm system **monthly** on emergency power (battery or generator). Not a code requirement, other than during annual test.

Fire Sprinkler System

1. Inspect automatic fire sprinkler system in accordance with 1998 NFPA 25, Chapter 2.
2. Inspect standpipe and hose systems in accordance with 1998 NFPA 25, Chapter 3.
3. Inspect fire pumps in accordance with 1998 NFPA 25, Chapter 5.
4. Inspect water storage tanks in accordance with 1998 NFPA 25, Chapter 6.
5. Inspect valves, components and trim in accordance with 1998 NFPA 25 Chapter 9.

Fire Extinguishers

1. Inspect fire extinguishers **monthly** in accordance with 1998 NFPA 10, Chapter 4. Date and sign the tag that is affixed to each fire extinguisher.
2. Follow procedures listed in 1998 NFPA 10, section 4-3.2

Generator

1. Inspect generator in accordance with manufacturer's recommendations per 1999 NFPA 110, Chapter 6, **OR** in accordance with 1999 NFPA 110, section A-6-3.1 if the manufacturer's recommendations are not available.

Doors

1. Recommended that all fire **and** smoke doors are tested **monthly** to ensure they close and latch in accordance with 1999 NFPA 80 Chapter 15. The testing frequency is to be determined by the facility based on the history of door failures within the facility.

Kitchen Hood Suppression

1. Inspect kitchen hood suppression (Ansul, Sprinkler, etc.) every 6 months in accordance with 1998 NFPA 96 section 8-2.

Battery Powered Emergency Lighting (Generator location, transfer switch location, egress paths)

1. Test battery powered lighting monthly for 30 seconds and annually for 90 minutes in accordance with NFPA 101 7.9.3.

Note: Specific testing, inspection results, and deficiencies shall be documented on an inspection and testing log. See example on next page.

TESTING AND INSPECTION LOG

Facility_____ Month/Year_____

Date Performed	Results of Testing/Inspections	Correction Required (Y/N)	Date Corrections Completed

The person responsible to ensure that the tests and inspections contained in this form have been performed in accordance with fire & life safety regulations and standards **shall** sign below as an attest that the facility has complied with these requirements.

Signature/Title_____ Date_____

Responsible Person

Quality assurance review performed: Date_____

FIRE DRILL FORM

Date: _____ **Time:** _____

Shift: ☐ Day ☐ Swing ☐ Night

Number of Occupants in Smoke Compartment: _____ **Time to Complete Simulated Evacuation:** _____

Notification Method Used: ☐ Audible Alarm ☐ Coded Announcement
(Only for drills between 9 p.m. & 6 a.m.)

Weather Conditions: _____

Problems Noted With Building: _____

Specific Type of Fire Simulated: _____

Location of Incident: _____

Comments on Staff Performance: _____

Staff Participating

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Person Conducting Drill

Administrator

FIRE AND LIFE SAFETY INSERVICE TRAINING

Date: _____ **Time:** _____

Person(s) Conducting Training: _____

Type of Training: ☐ All Staff In-Service ☐ New Employee Orientation
Shift ☐ Day ☐ Swing ☐ Night
Note: If training was performed for a specific shift, please indicate.

List Competencies Covered from Chapter 5: (Refer to Chapter 5 of this manual.)

Participating Staff Signatures

CO/NI _____	CO/NI _____
CO/NI _____	CO/NI _____
CO/NI _____	CO/NI _____
CO/NI _____	CO/NI _____
CO/NI _____	CO/NI _____
CO/NI _____	CO/NI _____
CO/NI _____	CO/NI _____
CO/NI _____	CO/NI _____
CO/NI _____	CO/NI _____
CO/NI _____	CO/NI _____

An evaluation of employee competence **shall** be indicated using the following criteria:

CO (Competency Observed) The individual is able to demonstrate the required knowledge and/or skill without assistance.

NI (Needs Improvement) The individual is either unable to demonstrate the requisite knowledge and/or skill or requires considerable coaching and/or assistance in order to complete the competencies.

FIRE WATCH DOCUMENTATION

Date: _____ Shift: ☐ Day ☐ Swing ☐ Night

Responsible Person(s): _____

Type & Number of Communication Device(s) Utilized:

- Cell Phone _____
- Portable Radio (In communication with whom?) _____
- Other (Describe) _____

Affected Areas of the Facility (Describe) _____

Reason for Fire Watch _____

Fire watch interval: ☐ 15 minute (Fire Alarm System)

☐ 30 minute (Sprinkler Systems &/or other hazardous conditions)

☐ Notification Fire Department ☐ **Notification OSFM 503-934-8202**

ATTEST STATEMENT

The above listed responsible person(s) have been designated as a fire watch, due to abnormal fire & life safety conditions and/or fire protection systems and equipment that are out of service. As such, during the fire watch these individuals performed constant patrols of the affected area(s) of the facility to keep watch for fires. In addition, these individuals had no other assigned duties other than performance of required duties for fire watch.

*The person in charge of the facility during this shift **shall** sign below as an attest that the above listed responsible persons have complied with the requirements for a fire watch.*

Signature/Title: _____
Administrator/Charge Nurse/Other Person in Charge

See Fire Watch Log Next Page

FIRE WATCH LOG

- ☐ 15 min (Fire Alarm System)
- ☐ 30 min (Sprinkler Systems &/or other hazardous conditions)

[illegible]

Note: Individuals responsible for conducting a fire watch shall conduct a complete walk-through of all affected areas in the time frame specified above. Reminder that these individuals also need to account for required breaks, etc.

TRAINING & EXERCISING THE EMERGENCY PREPAREDNESS PLAN

Facility: _____

Exercise: Rehearsed ☐ Table Top ☐ Exercise Date: _____

NFPA 99, 1999 Edition, Chapter 11 Section 11-5.3.9 Drills. Each organizational entity shall implement one or more specific responses of the emergency preparedness plan at least semi-annually. At least one semi-annual drill shall rehearse mass casualty response for health care facilities with emergency services, disaster receiving stations, or both.

Drills must be conducted on all portions of the plan. One per year may be a table top exercise and one exercise must be a rehearsal.

Participants

Exercise Completed	Action	Hazard/Disaster/Emergency
	Code Amber	Missing patient/elopement
	Evacuation-Emergency (partial or full)	Fire, explosions, chemical spills, gas leaks, industrial accidents, plane crash, terrorism, bombs, armed intruder, dam or levee failures, etc.
	Evacuation-Post Emergency (full)	All of the above, as appropriate, plus impaired building integrity, post sheltering-in-place, etc.
	Building Security	Threats of intruders or other acts of violence, bomb threat calls, community/mob threat or incident requiring security of the facility for patient safety, or recommendation of law enforcement to secure the facility.
	Building Ventilation	Volcanic eruption, external chemical spills, or bio-terrorism.
	Understaffing	Community, extreme weather, natural disaster, or infectious incidents affecting ability to secure appropriate staffing.
	Internal Search	Bomb threats, internal chemical events, intruders, theft, missing patient or elopement.
	Infectious Events	Pandemic influenza, Norovirus, bio-terrorism, etc.
	Outages	Loss of electric, heat, air conditioning, gas, water, sewage, pharmacy or food services.
	Armed Intruder	Staff management of armed intruders until law enforcement arrives.
	Weather-Related	Tornado, windstorm, severe cold weather, heat waves, etc.

Comments on Staff Performance: _____

APPENDIX B

FIRE & LIFE SAFETY REFERENCES

The following standards and codes are adopted by the state of Oregon and the federal government for ASC / ESRD'S. **NOTE:** *The editions of the NFPA Standards listed below are those adopted by CMS under the 2000 edition of the Life Safety Code. Later editions may be adopted by the Oregon Structural Specialty Code or Oregon Fire Code.*

All codes marked in bold are required to be accessible/on-site for facilities in order to properly maintain fire & life safety systems.

- | | |
|--|--|
| ↪ Oregon Fire Code (2010) | ↪ NFPA 25 Standard for the Inspection, Testing, & Maintenance of Water-based Fire Protection Systems (1998 Edition) |
| ↪ Oregon Structural Specialty (Building) Code (2010) | |
| ↪ Oregon Mechanical Specialty Code (2010) | ↪ NFPA 70 National Electrical Code (1999 Edition) |
| ↪ NFPA 101 Life Safety Code (2000 Edition) | ↪ NFPA 72 National Fire Alarm Code (1999 Edition) |
| ↪ NFPA 99 Health Care Facilities (1999 Edition) | |
| ↪ NFPA 10 Standard for Portable Fire Extinguishers (1998 Edition) | ↪ NFPA 80 Fire Doors & Other Opening Protectives (1999 Edition) |
| ↪ NFPA 13 Installation of Sprinkler Systems (1999 Edition) | ↪ NFPA 110 Standard for Emergency & Standby Power Systems (1999 Edition)
NOTE: If facility has a generator. |

APPENDIX C TRAINING RESOURCES

- | | |
|--|---|
| <p>◆ Media Resources, Inc.
2614 Fort Vancouver Way
Vancouver, WA 98661
Phone 1-800-666-0106</p> | <p>◆ Oregon Occupational Safety
& Health Division
350 Winter St NE, Room 430
Salem, OR 97310
Phone 1-888-292-5247</p> |
| <p>◆ National Fire Protection Association
1 Batterymarch Park
PO Box 9101
Quincy, MA 02269-9101
Phone 1-800-344-3555</p> | <p>◆ Office of State Fire Marshal
4760 Portland Road NE
Salem, OR 97305
Phone 503-934-8257</p> |

The Office of State Fire Marshal offers periodic specialized training workshops. Contact the Healthcare Unit at (503) 934-8202 regarding information pertaining to workshops.

APPENDIX D SMOKING POLICY

Smoking policies shall be created by all facilities and the policies shall be enforced.

Control of ignition sources (such as lighters and matches) is critical to the prevention of fires and elimination of burn injuries. Facility policies shall in all cases specify how staff will monitor who has possession of ignition sources both during patient use, as well as when not in use. Facility policies shall establish adequate controls to ensure that ignition sources are secured in a manner that minimizes the potential for injury to patients and for unwanted ignition of combustibles.

Smoking areas are to be kept clean of all discarded smoking materials, and provided receptacles are to be used.

The Oregon legislature passed a smoke free workplace law in June 2007. The new law will prohibit smoking within 10 feet of entrances, exits, windows that open, and ventilation intakes.

Smoking and Oxygen Use: Oxygen is not flammable, it is an accelerator. Oxygen increases the speed at which things burn once a fire starts. Nearly all materials, even metals, will burn vigorously in oxygen enriched environments. The air we breathe contains approximately 21% oxygen and most materials are tested for safety at that concentration. When pure oxygen is flowing near clothing, furniture, hair, and other materials they absorb the oxygen and become more susceptible to burning. "No Smoking" shall be enforced at a facility where oxygen is used. Even if it is not being used at a particular moment, the environment is still oxygen enriched and a fire can develop quickly. Keep open flames and smoking materials away from oxygen therapy equipment to prevent fatal fires.

When there is potential or identified conflict between the patient's right to smoke and/or the patient's continued smoking while using oxygen and the risk of harm to self or others, the provider(s) or others are to conduct a reassessment of the patient's smoking abilities. **In all cases patient safety will outweigh their right to smoke.**

Oxygen cylinders and other oxygen delivery equipment are not permitted within 20 feet of smoking shelters or smoking areas.

Oregon Fire Code 2010 Edition

SECTION 310
SMOKING

310.1 General. The smoking or carrying of a lighted pipe, cigar, cigarette or any other type of smoking paraphernalia or material is prohibited in the areas indicated in this section.

310.2 Prohibited areas. Smoking shall be prohibited where conditions are such as to make smoking a hazard, and in spaces where flammable or combustible materials are stored or handled.

310.3 “No Smoking” signs. The fire code official is authorized to order the posting of “No Smoking” signs in a conspicuous location in each structure or location in which smoking is prohibited. The content, lettering, size, color and location of required “No Smoking” signs shall be approved.

310.4 Removal of signs prohibited. A posted “No Smoking” sign shall not be obscured, removed, defaced, mutilated or destroyed.

310.5 Compliance with “No Smoking” signs. Smoking shall not be permitted nor shall a person smoke, throw or deposit any lighted or smoldering substance in any place where “No Smoking” signs are posted.

310.6 Ash trays. Where smoking is permitted, suitable noncombustible ash trays or match receivers shall be provided on each table and at other appropriate locations.

310.7 Burning objects. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material.

NFPA 99 1999 Edition
Standard for Health Care Facilities

9.6.1.1 Elimination of Sources of Ignition.

9.6.1.1.1 Smoking materials (e.g., matches, cigarettes, lighters, lighter fluid, and tobacco in any form) shall be removed from patients receiving respiratory therapy.

9.4.2.9 Smoking, open flames, electric heating elements and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations.

9.6.3.2* Signs.

9.6.3.2.1 In health care facilities where smoking is not prohibited, precautionary signs readable from a distance of 1.5 m (5 ft) shall be conspicuously displayed wherever supplemental oxygen is in use and in aisles and walkways leading to that area; they shall be attached to adjacent doorways or to building walls or be supported by other appropriate means.

9.6.3.2.2 In health care facilities where smoking is prohibited and signs are prominently (strategically) placed at all major entrances, secondary signs with no-smoking language shall not be required.

9.6.3.2.3 The nonsmoking policies shall be strictly enforced.

NFPA 101 2000 Edition
Life Safety Code

New/Existing Healthcare Facilities:

20/21.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:

- (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
- (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.
- (3) Smoking by patients classified as not responsible shall be prohibited.
- (4) The requirement of 20/21.7.4(3) shall not apply where the patient is under direct supervision.
- (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.
- (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

APPENDIX E

INTERPRETATIONS AND TECHNICAL ADVISORIES

1. Relocatable power tap clarification
2. OSSC interpretation Private Mode fire alarm systems
3. *Liquid Oxygen Trans-filling Regulations in Health Care Facilities*
4. Technical Advisory No. 08-03 *Holiday Décor and Fire Safety Guidelines*
5. CMS Survey & Certification Policy Letters
<http://www.cms.hhs.gov/surveycertificationgeninfo/pmsr/list.asp>

(Note: When conducting Fire & Life Safety surveys, the Office of State Fire Marshal is obligated to give consideration to these policies. However, the Office of State Fire Marshal may be more restrictive based on Oregon laws and rules.)

PROPER USE OF PLUG STRIPS

The Oregon Office of State Fire Marshal has clarified the use of approved plug strips. An approved plug strip can be used for the following applications:

- Computer CPUs.
- Computer monitor.
- Audio Visual equipment.
- Any device that uses a plug-in wall transformer (the small plastic cubes that plug into the building's electrical outlet), such as those used to charge cell phones, scanner, iPods, PDAs, Spectralink and 2-way chargers, other low-power electronic devices.
- Computer audio device, small radio/CD player.
- Small portable fan.
- Calculator.
- Desk lamp 100 watts or less.
- Ink jet printers (not laser printers).
- Pencil sharpener.
- Portable equipment carts.

Only the Tripp-Lite "Medical Grade" (UL60601-1) plug strips, and the Leviton HG (UL60601-1) plug strips are approved for use in patient care areas and vicinities (anywhere that patients/patients can access and within 6'). Plug strips in patient/patient areas are required to meet UL60601-1 standards for patient areas. Unless UL60601-1 listed, simply indicated as "Hospital Grade" plug strips do not comply with the standards.



"Medical-Grade" Power Strip

The following applications are not approved uses for a plug strip:

- More than one plug strip cannot be plugged into a building's electrical outlet.
- You cannot chain plug strips by plugging one plug strip into a second plug strip.
- You cannot connect microwaves, refrigerators or other appliances into a plug strip.
- You cannot connect servers and telephone systems to plug strips.
- You cannot connect Pyxis machines, laser printers or other large-demand devices into a plug strip.
- You cannot plug desk lamps or lights greater than 100 watts into a plug strip.
- You cannot use a plug strip as an extension cord. Use of extension cords is prohibited.
- Plug strips cannot be used as a convenience in lieu of permanent building wiring.
- Plug strips cannot extend through a doorway, cabinet or other openings that can close.
- Plug strips may not be on the floor.
- Plug strips cannot be attached to the building or structure so that a tool would be required to remove.



July 25, 2012

No: OSSC 907.2.6

Code Section:	907.2.6 and NFPA 72
Code Edition:	2010 Oregon Structural Specialty Code (OSSC) with 2012 Accessibility Amendments and NFPA 72-2010, Sections 3.3.169 and Chapter 18
Date:	July 25, 2012
Subject:	Fire Alarm Design in <i>Health Care Facilities</i> – Public vs. Private Mode
Question:	Does the OSSC allow a designer to choose whether to design a fire alarm system throughout a <i>Health Care Facility</i> to either <i>public mode</i> or <i>private mode</i> as defined in NFPA 72?
Answer:	Yes. Whether or not to design to NFPA 72 section 18.4.3 (<i>Public Mode</i>) or section 18.4.4 (<i>Private Mode</i>) is a discretionary design consideration throughout a <i>Health Care Facility</i>. Please note the following when using <i>Private Mode</i>: • In public areas, the decibel level is allowed to be reduced by 5db. (Reference NFPA 72-2010 Section 18.4.4.3.1 in Analysis) • The number of devices and locations can be reduced or eliminated in <i>Patient Sleeping and Treatment areas</i> and only be located at areas which are continuously staffed by personnel licensed through the <i>Oregon Health Authority</i>.
Analysis:	Occupant notification systems in <i>Health Care Facilities</i> are not required to be activated where private mode signaling is installed in accordance with NFPA 72. This interpretation recognizes that <i>Health Care Facilities</i> are subject to licensing requirements which are inclusive of rigorous training requirements for staff in the effective evacuation of all areas and spaces as well as “<i>defend in place</i>” techniques necessary for the safety of all patients and visitors. In addition, allowing <i>Health Care Facilities</i> to use <i>Private Mode</i> signaling throughout is consistent with the requirements of <i>Centers for Medicare and Medicaid Services (CMS)</i> as administered by the <i>Oregon Health Authority</i>. These requisites address the common practice in <i>Health Care Facilities</i> of only notifying the staff instead of all building occupants in the event of a fire.

In accordance with OAR 918-008-0110, the information contained in this statewide code interpretation is legally binding on any party involved in activities regulated by applicable Oregon law, applicable Oregon regulations or the state building code. If the information contained in this statewide code interpretation is cited as a basis for a civil infraction, a representative of the jurisdiction must cite the interpretation number found in this document.



When complying with *Private Mode*, NFPA 72 allows for the elimination of both audible and visible alarms in *Health Care Facilities* as dictated by the “*intent of the user and the authority having jurisdiction*.” This language is necessarily vague in order to meet the operational needs of healthcare experts for patient care areas where event notification (i.e., horns and strobes) can lead to heightened anxiety and overreaction by given patients and/or visitors. As noted above, staff are otherwise adequately trained in comprehensive evacuation and “*defend in place*” strategies.

This interpretation is also consistent with the fire alarm provisions of the *Federal 2010 ADA Standards Update*. Specifically, the exception to the fire alarm requirements of Section 702.1 of the *Update* notes; “*Fire alarm systems in medical care facilities shall be permitted to be provided in accordance with industry practice.*”

It is highly recommended that persons performing plan review through local building departments coordinate the approval of *Fire Alarm Systems* with the *Facilities Planning and Safety* unit of the *Oregon Health Authority* (see contact section below).

For the readers convenience, certain applicable NFPA 72-2010 sections have been provided:

- **3.3.169 Operating Mode.**
 - 3.3.169.1 *Private Operating Mode.* Audible or visible signaling only to those persons directly concerned with the implementation and direction of emergency action initiation and procedure in the area protected by the fire alarm system. (SIG-NAS)
 - 3.3.169.2 *Public Operating Mode.* Audible or visible signaling to occupants or inhabitants of the area protected by the fire alarm system. (SIG-NAS)
- “18.9.3.1 *Private Mode.* Unless otherwise permitted by the authority having jurisdiction, all textual visible notification appliances in the private mode shall be located in rooms that are accessible only to those persons directly concerned with the implementation and direction of emergency action initiation and procedure in the areas protected by the system.”
- “18.4.4.3.1. A system arranged to stop or reduce ambient noise shall be permitted to produce a sound level at least 10 dB above the reduced average ambient a or 5 dB above the maximum sound level having a duration of at least 60 seconds after reduction of the ambient noise level, whichever is greater ...” (et al)

Contact: Richard S. Rogers, Structural Program Chief
(503) 378-4472 or Richard.Rogers@state.or.us

Steve Judson, PE, Commercial Code Specialist
(503) 378-4635 or Steven.W.Judson@state.or.us

Pamela R. Triplett, Oregon Health Authority- Facilities Planning and Safety
(503) 373-7201 or Pamela.R.Triplett@state.or.us



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OREGON STATE FIRE MARSHAL

Fire & Life Safety Services

“Liquid Oxygen Trans-filling Regulations in Health Care Facilities”

Trans-filling of liquefied oxygen from one container to another shall be conducted in accordance with Oregon Fire Code Chapters 30, 32 and 40 and Articles 74 and 75 and NFPA 99 as follows:

1. Trans-filling shall only be conducted within a control area (room) that is separated from other portions of the building by a one-hour occupancy separation as specified in the *Oregon Structural Specialty Code* (Building Code). Rooms shall have at least one exterior wall. There shall be no more than two rooms within a health care institutional facility. If there are two rooms within a facility, the rooms shall be separated in a manner that a single fire is not able to jeopardize both rooms at the same time.
2. Rooms shall have automatic fire sprinkler protection designed in accordance with NFPA 13 as Ordinary Hazard Group 1. Sprinkler head locations and spacing shall be such that at least one head is capable of providing cooling for each cylinder/container in case of fire.
3. Rooms shall have ventilation as follows:
 - Where only one or two cylinders/containers are within a room, natural ventilation openings shall be located on the exterior wall; one within 6 inches of the ceiling and one within 6 inches of the floor.
 - Where more than two (2) storage cylinders/containers are within a room, the room shall be mechanically ventilated at or near the point of oxygen discharge generation and shall be capable of maintaining a negative pressure within the room compared to surrounding spaces.
4. Floors in rooms shall be bare concrete with no combustible seams. Ceramic flooring shall be considered on a case by case basis and requires fire marshal approval prior to use.
5. All cylinders/containers shall be limited in size to no larger than 72 pounds each (7.6 gallons/870 cubic feet). The number of cylinders/containers in each room shall be limited to a maximum of four (4).
6. Rooms shall be posted with signs indicating that trans-filling is occurring within the room and that smoking is prohibited within the immediate room and within 3 feet of doorways and/or openings which enter the room. In addition, entry doors into rooms shall be posted with NFPA 704 placard signs as follows: (3/0/0/OX).
7. Trans-filling shall be performed in accordance with CGA (Compressed Gas Association) Pamphlet P-2.6, *Trans-filling of Low Pressure Liquid Oxygen to be Used for Respiration*.

8. Health care institutional facilities shall develop written policies and train staff in trans-filling procedures that are consistent with nationally recognized standards specified in item #7. Patients shall not be allowed to trans-fill cylinders/containers at any time except as part of a patient rehabilitation-training program for an individual's personal use only.
9. Rooms shall be secured to prevent unauthorized access.
10. Rooms shall have emergency task lighting interconnected to the facility Life Safety Branch as required in NFPA 99.
11. All electrical equipment within rooms shall conform to the Electrical Code.
12. No sources of ignition (open flames, smoking) shall be allowed within rooms.
13. Rooms shall be for no other purpose than trans-filling and storage of liquefied oxygen. No materials shall be present within rooms which are incompatible with liquefied or gaseous oxygen; e.g. oil based products, solvents, atomized sprays, etc.
14. MSDS information sheets shall be maintained on premises.
15. Liquid oxygen cylinders/containers shall be transported on carts that provide a stable base. Liquid oxygen cylinders/containers shall not be transported within exits or within 10 feet of discharges (outside exit doors) from the means of egress.



OREGON FIRE MARSHAL

Healthcare Unit

Technical Advisory

Date: July 20, 2011

Subject: Holiday Décor and Fire Safety Guidelines

Code Reference: 2010 Oregon Fire Code

Subject: Guidance on the use of decorative items during traditional holidays but these guidelines may be utilized at any time of the year.

Contents: For the purposes of this technical advisory, the following shall apply:

EGRESS Access to exits and exit paths shall not be obstructed by decorative materials.

SOURCES OF IGNITION

- Candles and other sources of open flame are not allowed for any decorations or ceremonies, except as approved by the fire code official prior to the event.
- Sources of ignition shall not be allowed within the vicinity of combustible decorative materials.

ELECTRICAL

- Electrical lights and cords that are physically damaged or altered shall not be used.

DECORATIVE MATERIALS

- Decorative materials are materials applied over interior finishes such as curtains, drapes, fabrics, streamers and other surface coverings, batting, cloth, cotton, hay, stalks, straw, vines, leaves, trees, moss, and similar items including foam plastics.
- Natural cut vegetation, including natural cut Christmas trees.

Fire-retardant coatings are not required or recommended on natural cut trees and will not extend the length of time a tree should be permitted indoors. While freshly cut trees are naturally flame resistant due to their high water content, they become extremely flammable when permitted to dry out. When brought indoors, the heat and lower humidity will accelerate the drying process.

Care of Christmas trees shall be as follows:

- Sawed off at least one inch above the original cut.
 - Mounted securely in a tree stand, pail, tub, or other water-type holder or reservoir.
 - Maintain the water level above the cut as long as the tree is indoors and add fresh water daily.
 - Avoid placement near heating sources including fireplaces, air vents and space heaters which can accelerate the drying process and may also pose an ignition hazard.
- All decorations shall be either inherently fire retardant or treated with a flame retardant to be flame resistant and shall comply with the Oregon Fire Code 2007 Edition, Section 807.
 - The means of egress shall not be obstructed by decorative vegetation or materials.
 - Natural cut Christmas trees are prohibited in health care type occupancies.
 - Exceptions:**
 - 1) Trees located in areas protected by an approved automatic sprinkler system excluding patient rooms.
 - 2) Trees in patient rooms that meet one of the following:
 - a) A live Christmas tree not exceeding 24 inches in height, including the pot. Pots shall not exceed 9 inches in diameter.
 - b) An artificial tree of non-combustible material not exceeding 24 inches in height.
 - No electrical decorations are allowed on Christmas trees in patient rooms.
 - Exception:** Battery operated listed miniature or LED style lights may be used with the approval of the facility.
 - Decorative material shall not exceed more than 30% of corridor wall area.
 - Artificial decorative vegetation, e.g., artificial Christmas trees shall meet the flame propagation performance criteria of NFPA 701 and shall be documented and certified by the manufacturer in an approved manner.
 - Listed miniature or LED style lights may be used in patient rooms around the inner framing of a window with the approval of the facility.
 - Contact local fire authority for fireworks displays. Contact the Office of State Fire Marshal for required permits.

Other References: NFPA 101

APPENDIX F

EMERGENCY PREPAREDNESS CHECK LIST

Development, Implementing, Revising, and Maintaining of Emergency Preparedness Plans

☐	An emergency preparedness plan has been prepared and is being maintained by the facility administration.	☐ Is there a written emergency preparedness plan specifically developed for the facility and its location? (i.e., not a generic corporate plan)
☐	The emergency preparedness plan has been reviewed and/or updated within the last twelve months, or as necessitated by changes in staff assignments, changes of occupancy, or the physical arrangement of the building.	☐ Does the plan indicate when it was last reviewed? ☐ Have there been any changes within the last twelve months that may have necessitated revisions to the plan? ☐ Is the plan current to all required changes? Staff contact list, current agreements, facility floor plan?
☐	The emergency preparedness plan is immediately and readily available in the workplace for reference purposes by facility staff members during in-service training activities, drills, and during actual emergencies.	☐ Have staff been advised where plans are located and how to access the plan? ☐ Are plans at locations such as nurse's station where staff can access them?
☐	The emergency preparedness committee has written responsibility for overall disaster planning and emergency preparedness within the facility. The committee is under the supervision of an individual specifically designated by facility administration.	☐ Is there a written policy to designate the committee responsible for plan over site? ☐ Is there a written policy that designates the individual responsible for plan over site? ☐ Is there documentation of committee activities and decisions regarding the plan? (i.e., meeting minutes)
☐	The emergency preparedness committee has conducted an analysis of local hazards including the identification of said hazards, the likelihood that identified hazards might occur, and a risk assessment of the vulnerability of those hazards related to the facility, to its occupants, and to facility staff.	☐ Has the committee contacted the local Emergency Manager to coordinate development of the plan? For a list of local emergency management offices, go to: http://www.oregon.gov/OMD/OEM/docs/plan_train/locals_list.pdf ☐ Has hazard/risk assessment been conducted and reviewed when necessary or within the last twelve months? ☐ Does the plan address all identified local hazards that are a potential threat to the facility and occupants such as a pandemic, earthquake, or fire?

Training and Exercising of Staff on Emergency Preparedness Plans

☐	The facility administration has implemented a staff educational program to ensure that all staff members understand their specific duties and assignments as outlined in the emergency preparedness plan, and how the emergency preparedness plan will be activated and terminated.	☐ Has the emergency preparedness plan been reviewed by all employees during facility in-service training within the last twelve months? ☐ When asked, does staff know their duties as specified within the plan?
☐	The facility administration has implemented at least semi-annual drills of the emergency preparedness plan to ensure that all staff members have practiced and/or rehearsed their specific duties and assignments, as outlined in the emergency preparedness plan when it is activated and terminated.	☐ Have at least two drills of the plan, not including fire drills, been conducted and documented within the last twelve months? ☐ Have drills been conducted on all portions of the plan including all hazards that are included within the plan OR is there a written schedule to accomplish this task?

Chain of Command during Emergencies

☐	The emergency preparedness committee has modeled the emergency preparedness plan based upon the incident command system in coordination with local emergency response agencies.	☐ Does the plan follow the Incident Command System as modeled by the federal government (NIMS)? ☐ Has the facility contacted their local Emergency Manager to establish a working relationship?
☐	The emergency preparedness plan chain of command has been organized in a manner that lists specific positions that are required to perform certain tasks as outlined in the emergency preparedness plan.	☐ Does the plan include a chain of command to be followed during any disaster? ☐ Does the plan indicate, by position, who is in charge of the facility during all times when the facility is occupied?

Structure and Specific Content of Emergency Preparedness Plans

☐	The emergency preparedness committee has implemented a strategy within the emergency preparedness plan to either eliminate identified hazards or to mitigate the effects of hazards that cannot be eliminated.	☐ Does the plan contain strategic procedures to address all local hazards that could likely present a potential threat to the facility and its occupants? ☐ Do plan sections coincide with the identified local hazards analysis?
☐	The emergency preparedness plan has a procedure for designating activation and deactivation criteria. This includes the events and/or operations thresholds that necessitate activation and deactivation of the emergency preparedness plan, and the designated individual by position to make these decisions.	☐ Is there written activation and deactivation procedures included within the plan? ☐ Does the plan indicate who will make decisions regarding when the plan is initiated and terminated?
☐	The facility has provided a contingency plan for natural disasters, if applicable, including but not limited to the following: • Earthquakes • Tsunamis • Weather related events (snow, wind, lightening, ice/hail, temperature extremes) • Fires external to the facility	☐ Does the plan contain strategic procedures to address natural disasters?
☐	The facility has provided a contingency plan for technological and industrial emergencies, including but not limited to the following: • Fire within the facility • Explosions within the facility • Hazardous materials releases • Bomb threats • Contamination of inside/outside air supply • Communications failure	☐ Does the plan contain strategic procedures to address technological and industrial emergencies?

Structure and Specific Content of Emergency Preparedness Plans (cont.)

☐	The facility has provided a contingency plan for continuity of essential building systems and services, including but not limited to the following: • Water • Electricity • Heating, air conditioning, ventilation • Elevator • Power/utility failure • Fuel/resource shortage • Fire protection systems and equipment failure • Medical gas and vacuum systems	☐ Does the plan contain strategic procedures to address continuity of essential building systems and services? ☐ Does the plan include a map with utility shut-off locations, such as water, electric and gas supplying the building?
☐	The facility has provided a contingency plan for other types of emergencies, including but not limited to the following: • Missing patient • Influx of patients from another facility • Mass casualty • Business interruption • Staffing limitations	☐ Does the plan contain strategic procedures to address other types of emergencies?
☐	There is a plan for management of patients with respect to clinical and administrative issues, including but not limited to the following: • Patient modification of care plans and/or discontinuation of nonessential services • Control of patient information • Handling of patient personal property and medical records • Admission/discharge and transfer of patients	☐ Does the plan contain strategic procedures to address patient clinical and administrative issues during emergencies? NOTE: This shall be evaluated by health care surveyors (not fire marshals).

Structure and Specific Content of Emergency Preparedness Plans (cont.)

☐	There is a plan for alerting and managing of facility staff during an emergency that includes considerations for housing and transportation of staff and their families. The plan includes but is not limited to the following: • Management of staff space and transportation • Recall and augmentation of staff • Human resource needs • Critical incident stress debriefing	☐ Does the plan contain strategic procedures to address facility staffing during emergencies? ☐ Do all personnel designated or involved in the emergency preparedness plan have access to a means of identification, which is required to be worn at all times? ☐ Does the plan have relevant policies, procedures, job descriptions and/or bargaining agreements regarding mandatory overtime, changes in shifts, potential to bring dependents and/or pets onsite or to alternate sites, expectations in event of an evacuation, potential use of volunteers, etc. ☐ Is there a critical incident stress debriefing policy?
☐	There is a plan for the stockpiling or ensuring of immediate or uninterrupted access to critical materials for a minimum of 5 days, unless licensing regulations allow less. This includes food, water, medications, medical supplies, and medical records necessary to obtain care and treatment.	☐ Does the plan contain strategic procedures to address stockpiling and/or access to critical materials during emergencies? NOTE: This shall be evaluated by health care surveyors (not fire marshals).
☐	The Pandemic section of the plan addresses infection control measures, such as closing the facility to outside visitors, increased usage of barriers (masks, gloves, etc.), and strict hand washing.	☐ Does the plan contain strategic procedures to address Pandemic control measures? NOTE: This shall be evaluated by health care surveyors (not fire marshals).
☐	There is a plan to address facility internal and external security needs, including but not limited to the following: • Access and egress from the facility • Control of crowds • Needs of security staffing • Control of traffic flow and parking	☐ Does the plan contain strategic procedures to address internal and external security during emergencies?

Structure and Specific Content of Emergency Preparedness Plans (cont.)

☐	There is a plan to address public affairs issues, including but not limited to the following: • Designation of a media spokesperson • Designated media area to facilitate control and not interfere with facility operations	☐ Does the plan contain strategic procedures to address public affairs issues during emergencies?
☐	There is a plan to address those measures needed to restore the facility and staff members to pre-disaster operational levels.	☐ Does the plan contain strategic procedures to address restoration of the facility following cessation of an emergency?

Evacuation, Relocation, and Sheltering In Place During Emergencies

☐	The emergency preparedness plan includes dated agreements for both short (less than 96 hours) and long term (96 hours or more) alternate care facilities.	☐ Are written agreements currently valid? ☐ Is the alternate long-term facility equivalent in licensing and services? ☐ Is one facility at least 50 miles away to account for a regional disaster? NOTE: “Currently valid” means created and/or reviewed within the last 12 months.
☐	The emergency preparedness plan includes on-site evaluations and a facility layout of the short and long term alternate care facilities.	☐ Has an on-site evaluation of alternate care facilities been conducted? ☐ Does the plan contain diagrams indicating layout for use of alternate care facilities during emergencies?
☐	The emergency preparedness plan includes a transportation plan for relocation to short and long term alternate care facilities. If the facility serves individuals who use wheelchairs or life-sustaining equipment, the plan indicates how those individuals and their equipment will be transported.	☐ Is there a written transportation plan? ☐ Does the plan reflect availability of transportation during wide-spread (local area or regional) emergencies? ☐ Are there alternate plans if primary transportation services are not available?
☐	Care records are available during an evacuation, and include each patient's current medical and treatment plans, a list of the current health conditions, a list of allergies, and an indication of any special or unusual support needs, such a special diets, fluid instructions, support for behavior, etc,	☐ Does the plan contain how patient medical records will be handled during emergencies? NOTE: This shall be evaluated by health care surveyors (not fire marshals).

Evacuation, Relocation, and Sheltering In Place During Emergencies (cont.)

☐	Procedures are included for employee and occupant accountability after evacuation and/or relocation has been completed. This includes the method of physically identifying each occupant by name and originating facility and a procedure to track and report the location of each occupant to the Department of Human Services, local office or designee.	☐ Are there procedures to account for staff and other occupants including visitors after they are evacuated and/or relocated from within the facility? ☐ Is there a tracking system in place for patients that have been moved to alternate care facilities and/or locations?
☐	There is a planned manner of identifying patients which allows for the identification of those unable to communicate. There is a method of tracking the physical location of patients.	☐ Is there a means of identifying patients during emergencies, such as plastic ID bracelets, ID on a lanyard around the neck or other form of semi-permanent identification attached to or upon the person? ☐ Is there a means of tracking the physical location of patients, such as a notebook, card index, or other system?
☐	The plan to shelter in place demonstrates how patients will stay warm during emergency conditions, to avoid life-threatening heat or cold, and how sanitation will be maintained in the event of an extended utility outage.	☐ Is there a plan for sheltering in place within the facility? ☐ Does the plan contain how the facility will be evaluated for safety and livability? ☐ Are the facility fire protection systems and patient services/equipment designed and capable of operating for extended period of time not less than 96 hours?

Fire Evacuation and Fire Safety of Licensed Care Facilities

☐	Procedures are included for the preferred and any alternative means of reporting fires and other emergencies to the fire department or designated emergency response organization.	☐ Is there an alternate means to notify the fire department of an emergency?
☐	The plan designates emergency egress or escape routes and includes whether evacuation of the building is to be complete, or patients may be relocated to selected floors, smoke compartments or other points of safety within the facility. When all patients must be relocated out of the facility, the plan indicates where they will be taken and kept safe from extremes in weather.	☐ Does the plan contain strategic procedures for the relocation and/or evacuation of patients/patients and staff? ☐ Does the plan include a method for indicating when a room has been checked and evacuated? ☐ Does the plan include procedures for areas outside of the fire area? ☐ Are there provisions for protecting patient/patients from weather extremes during emergencies?
☐	Site plans and floor plans included in the Fire Safety Plan include all exits, primary, secondary, and accessible evacuation routes, areas of refuge, manual fire alarm boxes, portable fire extinguishers, fire alarm controls, and fire and smoke barriers and compartments.	☐ Are there facility plans that include protection features and controls? ☐ Are these plans accessible by staff and/or otherwise used during training and drills?
☐	Procedures are included for the preferred and any alternative means of notifying facility occupants of a fire or emergency including designated life safety strategies for relocating or evacuating occupants.	☐ Are there an alternate means to alert patients and other occupants of an emergency? If codes are used, are they standardized? ☐ Are there written evacuation and relocation plans?

☐	There is a list identifying assigned personnel responsible for maintenance of fire protection systems and equipment installed to prevent or control fires.	☐ Is there a written policy designating personnel responsible for fire protection systems and features? ☐ Does the plan designate personnel responsible for maintenance, housekeeping, and controlling of fire hazard sources? ☐ Are there procedures to account for employees, including where they shall remain within the facility to operate critical equipment before evacuating or relocating?
☐	Plan is organized and easy to navigate.	☐ Are procedures easy to locate in the plan? (i.e., table of contents, marked by tabs, flip-chart design?) ☐ Are all maintenance and non-emergency policies kept in a separate from the emergency preparedness plan?