RACE confusion shouldn’t obscure its intent during fire response

The abbreviation RACE is among the more common buzzwords in fire response training at health care facilities.

A debated point is what the letters should really stand for: Do they mean Rescue, Alarm, Confine, and Evacuate? Or is the “E” for Extinguish? And are the steps prescribed in RACE in the right order?

Life safety experts, facility managers, and others have various opinions, but all urge their colleagues not to let semantics weigh the real issues down.

“Memorizing [the RACE actions] doesn’t really help you if you don’t understand the meaning of them,” says Richard Fasano, a principal at Russell Phillips & Associates in Elk Grove, CA.

Two key points
The following two points may help make RACE work for you:

1. Staff training must play

EC design among JCAHO focal points during random unannounced surveys in 2000

Environment of care (EC) design is among the five fixed grid elements that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will focus on during random unannounced surveys for hospitals in 2000.

Under its new policy, the Joint Commission will tailor its random unannounced surveys this year to make them specific to each organization, but the JCAHO has also identified five “high-risk” performance areas for hospitals, which are listed below in order of priority.

The high-risk areas are as follows:

1. Improving organization performance: aggregation and analysis
2. Patient care: medication use
3. Medical staff: credentialing
4. Care of patients: special procedures
5. Management of the EC: design

EC design cuts through a wide swath of EC standards in the Comprehensive Accreditation Manual for Hospitals, including the design of buildings (EC.1.1 and EC.1.2) and the design of...
Success with an emergency evacuation at an assisted living facility reflects training

A recent early-morning evacuation of 90 residents at an assisted living facility was successful because of a well-structured emergency preparedness plan and up-to-date staff training.

The evacuation was necessary in November after workers noticed a strange odor at Sunrise Assisted Living in Annapolis, MD.

“I didn’t want to take any chances,” recalls Brian Robinson, Sunrise’s executive director. “So I said, ‘Just call 911, and they’ll make that decision [of what to do] when they get there.’ ”

Firefighters arrived at about 7:30 a.m., found two natural gas leaks in a furnace room, and ordered that the building be evacuated.

Residents kept safe
Staff members and emergency personnel moved the facility’s residents to a church across the street, which serves as a designated area for relocation during an emergency.

As soon as the residents were safely inside the church, Robinson and some staff members went to a nearby private school to contact the residents’ families. Not only were family members not upset by the situation, but many offered their help to make sure that all of the residents were safe, according to Robinson.

Firefighters and employees used a resident roster to check each resident’s whereabouts and medication needs, and also went door-to-door to ensure that each resident got out safely, he says.

Resident roster a key provision
Having an available list of residents was a key provision of emergency preparedness in this case.

“We have a resident roster that we always keep up-to-date daily,” Robinson says. “That’s the first thing that the shift supervisors know to grab when they’re having a fire drill or an evacuation of some sort.”

It’s a sizeable task to evacuate 90 residents, 30 of whom have Alzheimer’s disease or other dementia.

Training reinforces strategies
Robinson believes prior training and drilling definitely helped the evacuation go smoothly. (For 12 tips on conducting drills in your assisted living facility, see the list on p. 3.)

All Sunrise employees go through four days of training when they start work at the assisted living facility.

“Most of it is classroom,” Robinson says. “The only part that isn’t a tour with the maintenance man. They go over all of the fire procedures and what to do in case of a fire, and also how to use an extinguisher. They go outside the building and use one. And of course, we have a lot of videotapes that go with each level [of training].”

Some life safety experts warn that training should emphasize activities the employees will have to do on their own, such as extinguishing clothing fires (see “In focus” on p. 11 for more details) or moving needed medical equipment during an evacuation. While most people will remember hands-on extinguisher training, they may never end up using such training during a real-life fire, says Russell Phillips, president of Russell Phillips & Associates.

State regulations in Maryland require fire drills once per month, but Sunrise goes beyond that requirement and holds drills once per month on each shift. Robinson feels that the repetition keeps people alert with drill procedures.

What the building offers
The building’s modern protection features also helped safeguard the residents and staff members, Robinson explains.

The two-story, four-year-old building looks
## A dozen tips for better fire/evacuation drills in assisted living facilities

1. Your facility should have a site identified where you can transfer residents safely.

2. Minimize warning your staff in advance when you conduct a fire/evacuation drill to make it more life-like.

3. Many assisted living regulations specify frequency and documentation of drills. It is always a good idea to check with your local or state public safety regulators for minimum requirements on frequency of drills. To cover several possible scenarios, you should conduct the drill at different times of day and different days of the week. Also, it’s important that all staff members and residents take part in these drills, so they know their responsibilities during a fire or emergency.

4. During the drill, alert staff members of what the drill simulates. Is there a fire, earthquake, or gas leak? Is it a blaze in the wastebasket or is a computer on fire? Is there smoke in the corridor?

5. Many employees are hesitant to set off a fire alarm, even in an emergency. Have a disconnected alarm station that they can practice pulling. The same concept goes for fire extinguishers.

6. Keep an updated roster of the location of your residents and their medications. Make sure someone is in charge of the roster and regularly updating it. During the drill, go through the steps of checking the whereabouts of all residents and staff members.

7. An assigned staff member should take the emergency contact list of residents’ family members when exiting the building.

8. Drills should also include quizzing staff members on the locations of fire extinguishers, evacuation destinations, fire alarm pull stations, and other safety features.

9. Have a sufficient number of trained observers to verify that all areas of the building respond properly to a drill, not just those near the simulated fire.

10. Your plan should indicate who is responsible for calling the fire department. Before the drill, check with the fire department to find out whether they will participate in the drill. Then, during the drill the assigned staff member should be responsible for making the call.

11. Make sure that your staff members perform the entire drill. The drill is not over until everyone is in a safe area, such as a designated smoke compartment or out of the building. You can’t just hope that in a real emergency your staff members will know what to do if they haven’t finished the entire drill.

12. After the drill, evaluate your staff’s performance. It is helpful to have evaluation forms that you can use to summarize problems, offer corrective actions, and serve as documentation for authorities and surveyors. Test every part of the plan. Find out how the drill went from the beginning to the end.
Emergency evacuation

like a large Victorian home, but is in reality a steel structure with a high-tech alarm system, a smoke barrier system, and fire-resistant walls and carpeting, according to Robinson. Its alarm system has emergency lighting that tells the residents an emergency is taking place.

If the alarm panel notes a smoke detector or sprinkler activation, the smoke barrier doors close. Meanwhile, staff members respond to residents who are in an unsafe area and help evacuate them to another section of the building.

Robinson says in general, Sunrise hesitates to evacuate the building.

“Even if the building [were] on fire, even a large fire, the residents would probably not evacuate the building,” Robinson says. The building’s sections would then close off and “we’d move the residents by that time [to a safer area].”

However, with an odor of gas in the building, as was the case at Sunrise, evacuation is a more likely response until any danger can be found, Robinson adds.

Assisted living and the Life Safety Code

<table>
<thead>
<tr>
<th>Assisted living facilities are not considered health care occupancies under the Life Safety Code® (LSC) unless you have four or more people incapable of self-preservation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Since assisted living centers only “assist” these people, you generally consider them capable of self-preservation.</td>
</tr>
<tr>
<td>Typically assisted living facilities fall under Chapters 22 and 23 in the LSC, which cover new and existing residential board and care if the residents receive personal care. The LSC says residential board and care provides “care of residents who do not require chronic or convalescent medical or nursing care” and are otherwise capable of self-preservation.</td>
</tr>
<tr>
<td>Another way of looking at this issue is as follows: If the people received no personal care, then the facility would just be a common apartment, hotel, or lodging house. However, once the facility provides personal care, the facility serves as something more.</td>
</tr>
<tr>
<td>On the other end of things, if the care is such that occupants aren’t capable of self-preservation, then the facility is a health care occupancy.</td>
</tr>
<tr>
<td>Residential board and care falls somewhere in the middle and assisted living facilities would lie in that area, HLSC believes.</td>
</tr>
<tr>
<td>However, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) seems to go with the idea that assisted living falls under hotel/dormitory (Chapters 16 and 17 in the LSC) or lodging/moming (Chapter 20), depending on the number of beds, especially as far as completing a Statement of Conditions goes.</td>
</tr>
<tr>
<td>This issue can be tricky because the NFPA, JCAHO, and your local authority having jurisdiction may all evaluate an assisted living facility differently.</td>
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**Life Safety Code** changes that you should know about

In the last issue, HLSC ran an overview of changes to the new 2000 edition of the Life Safety Code (LSC). The following list is a rundown of health care-specific changes that all hospitals and ambulatory health care centers should be aware of, including some items that did not make it into our prior story:

- The LSC’s health care chapters will now be 18 (new health care occupancies) and 19 (existing health care occupancies).

- In Chapters 18 and 19, the LSC will allow a hospital or nursing home to change to a limited care facility and not have it count as a change in occupancy, thus not having to meet requirements for new construction.

- In Chapters 18 and 19, the LSC will offer specific wording exempting nonrated corridor doors from compliance with NFPA 80, Fire Doors and Fire Windows. The wording addresses the NFPA’s intent to allow undercuts of corridor doors to be a maximum one inch. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accepts this thinking; however, the JCAHO allows it to be a one-inch average undercuts whereas the NFPA does not address any average.

- In Chapters 18 and 19, the LSC will permit the use of friction catches or magnetic catches to hold open non-fire-rated doors.

- In Chapters 18 and 19, the LSC will strengthen language that prohibits presignals for fire warning systems. However, critical care areas will be allowed to remove or silence audible alarm devices and rely only on visual signals.

- In Chapter 19, a new exception will allow existing 28-inch corridor doors to remain if fire plans don’t call for patients in beds, wheelchairs, or gurneys to evacuate through these doors. The revision targets older nursing homes.

- In Chapter 19, the LSC will delete maximum window heights for existing facilities. Again, this revision targets older nursing homes.

- Ambulatory health care facilities will have their own chapters separate from the health care chapters (new Chapters 20 and 21).

- The LSC will reintroduce a definition of ambulatory health care that specifies that such occupancies are facilities that use anesthesia to render outpatients incapable of self-preservation without assistance from others. The change is an editorial correction.

- Ambulatory health care facilities will be allowed to omit smoke barriers if the occupancies are less than 10,000 square feet in area and protected by sprinklers.

Additionally, all facilities should look at the new performance-based design option in Chapter 5. Performance-based design uses life safety goals, rather than the strict requirements of the LSC, to demonstrate protection levels in buildings. For more details about performance-based design, see the August 1999 issue of HLSC.

**Editor’s note:** Please be aware that as of press time, there has been no official word that the Joint Commission on Accreditation of Healthcare Organizations or the Health Care Financing Administration will adopt the 2000 LSC.

### Ordering the new Life Safety Code

The NFPA’s new 2000 edition of the Life Safety Code will be available in March, but the NFPA is accepting orders for the code now. Additionally, an updated Life Safety Code Handbook is also available.

Call the NFPA for more information at 800/344-3555, Monday through Friday, 8:30 a.m. to 8 p.m. Eastern Time.
management plans (EC.1.3–EC.1.9).

EC.1.1 requires compliance with the Life Safety Code and completion of the JCAHO’s Statement of Conditions.

More varied surveys
In the past, hospitals knew the areas surveyors would target because the JCAHO identified the focus areas each year.

Now, based on presurvey information for each individual organization—such as a previous accreditation report, known sentinel event, or any consumer complaints—surveyors will look at organization-specific variable performance areas.

However, the JCAHO has also published fixed elements for random unannounced surveys that it listed in priority order based on the degree of actual or perceived risk to resident care and noncompliance with relevant standards in each area.

Grid elements aren’t first priority
The JCAHO says surveyors will first look at the organization-specific elements and then, based on the amount of time left, assess the fixed grid elements.

In organizations that require significant attention to variable performance areas, surveyors may only have time to address the highest priority fixed elements.

In all accreditation programs, the “Improving organization performance: aggregation and analysis” grid element is ranked highest, which will allow surveyors to review an organization’s process for responding to sentinel events.

Changes are response to critics
Keep in mind that the JCAHO has made changes to its random unannounced survey process starting January 1, and that it announced the changes during its executive briefings held in August 1999.

The changes came on the heels of a Department of Health and Human Services’ Office of the Inspector General report that cited major deficiencies in the external oversight system intended to make sure the nation’s hospitals are safe.

While in the past organizations had 24 hours’ notice, they now won’t have any notice that surveyors will arrive on their door for a random unannounced survey.

Also, the JCAHO expanded the time frame, and hospitals will be eligible for a random survey if they have had their triennial survey between nine and 30 months prior.

The first organizations eligible for a survey under the changed policy are those that were surveyed between July 1997 and April 1999.

The JCAHO performs these random unannounced surveys on 5% of its accredited organizations each year.
a pivotal part in how your facility deals with the RACE strategy

2. RACE is a flexible idea that a facility can mold to its specific set-ups

“Obviously there is far more to any acronym like RACE than just what the letters stand for,” says David Birk, MS, PE, technical editor for HLSC. “Staff training must handle the details and drills should evaluate if the RACE you use works for your facility, whatever you decide it stands for.”

Murray Hayward, CSO, safety officer at the University of Utah Hospitals and Clinics in Salt Lake City, UT, agrees, feeling that overall training by each facility will make the RACE principle work better in any given setting.

“The greatest value of using an acronym is to help masses of employees learn and perform a proper response to an emergency situation,” Hayward says.

He later adds, “[But] I feel we have only been successful with [RACE] because of the other supports that have been implemented, such as fully sprinklered buildings, the ban on smoking, and better automated detection and reporting systems.”

Extinguish or evacuate?

There are divided opinions among facility managers and safety officers over whether the “E” in RACE is for extinguish or evacuate.

Some hospitals train employees to evacuate patients if possible to avoid dealing with smoke and flames.

Others believe that there should be some attempt to extinguish a fire if it is in its incipient stage or is of a size no bigger than a trash can.

“My personal opinion is that, in general, ‘E’ should stand for extinguish,” Birk says. “Health care facilities are required to have portable fire extinguishers and staff [members] are required to know how to use them, as well as [know] other basic fire safety methods appropriate for your facility. For this reason, staff should attempt to extinguish the fire . . . as long as this can be done safely,” he continues. “Failing to extinguish the fire, the next course of action is to evacuate. Thus, evacuation should only be required if extinguishing fails.”

Russell Phillips, president of Russell Phillips & Associates in Rochester, NY, says it’s crucial that any attempt to extinguish an incipient fire is done by the staff member discovering the fire.

Attempts by employees to extinguish a fire even a few minutes after it is discovered can be extremely dangerous, particularly if people re-enter a room where the door has been closed to prevent fire and smoke from spreading, Phillips warns.

Remember that containing a fire under RACE is more than just closing a patient room door, Fasano says. It also includes closing any interconnecting bathroom doors, closing windows, and shutting down individual air conditioners that could draw smoke back into a room. Training people about what confine means is essential, he adds.

Don’t confront larger fires

Summa Health System in Akron, OH, encourages its employees to attempt to extinguish incipient fires, says Howard Hunt, safety officer for the system. But Hunt adds that employees should not fight structural fires, such as when flames engulf walls, ceilings, flooring, or large pieces of furniture or equipment.

Birk acknowledges that staff members—even the best trained—will not be able to extinguish certain fires, and during this evaluation of the fire scene, it may make the most sense to evacuate.

Staff members should end any fire-fighting effort if they feel the fire has grown too large for them to safely handle.

And if your facility has a well-trained fire response team, the team may prefer all staff members to close the doors to the room of origin and evacuate . . .
others from the area, and then let the team members tackle the blaze, Birk adds.

Dual meanings
Some facility managers embrace the idea that “E” can stand for both extinguish and evacuate depending on the severity of the situation.

“I teach the ‘E’ in RACE as follows: ‘E’ stands for extinguish when a fire is in a small stage of growth—trash can size,” says Charlie McCardle, safety officer of the Mental Health Institute in Independence, IA.

“When a fire starts to climb the wall and reaches the ceiling, ‘E’ stands for evacuation. At this point, it is time for the professionals,” McCardle adds.

He further explains that regular employees usually don’t have enough training to handle any fire beyond incipient stage. And he feels time is critical when a fire reaches a ceiling because of how quickly it can grow.

Different settings, different RACE
One safety officer has found it best to use two versions of RACE: one for within the hospital and one for other associated facilities.

“Inside the hospital, we say ‘E’ stands for extinguish, because we do not routinely evacuate,” says Gerald Bottomley, CPP, director of safety and security at Good Samaritan Community Healthcare in Puyallup, WA. “In any facility other than the hospital, we say it stands for evacuate because we will always evacuate any building other than the hospital [during a fire].”

Bottomley says that all employees, regardless of whether they work in the hospital, learn both procedures.

“I believe all employees need to know how to respond to a fire alarm if they are in the hospital, even if they primarily work outside the hospital,” Bottomley explains.

McCardle makes RACE review an important part of the facility’s annual safety training. Employees also demonstrate hands-on training with a water fire extinguisher at that time. “We adapted an old fire extinguisher and hooked a garden hose to the extinguisher,” he says. “This provides an inexpensive practice tool for annual fire extinguisher training.”

When to sound the alarm
There is also some dispute with the RACE abbreviation when it comes to the order in which someone sounds an alarm (the “A” in RACE).

Alerting other employees about a fire is a crucial step. The order of actions stemming from RACE depends on the situation you face, according to Chuck Davis, director of support services at Central Texas Medical Center in San Marcos, TX.

For example, “If an employee sees smoke coming from a patient room and the employee is standing next to the manual pull station, the alarm would be the first priority,” Davis says. “If the pull station is at the other end of the hall, some other action might make more sense. In any event, calling Code Red—or whatever term you use—loudly is always the first thing so that you can get immediate help.”

Training and drills at Central Texas Medical emphasize the quick use of a code word when someone notices a fire or smoke.

Don’t delay warnings
Using RACE, you should rescue anyone immediately in danger from the flames, but at the same time you don’t want to “delay the initiation of the signal to the fire department,” Hayward says. “Delay is [among] the most significant [factors] in multiple deaths due to fire.” Training at Washoe Medical Center in Reno, NV, teaches employees to say “Code Red” in a loud,
clear voice before rescuing anyone, says James Miller, MS, safety officer there. Any rescue cannot be delayed because of patient safety concerns, Miller adds.

“For this reason we do both [actions] at the same time . . . This way other employees will be able to help,” he says.

Birk recommends that anyone who discovers a fire but then takes the RACE strategy too literally may be missing the point.

Some people believe that putting “R” for “rescue first is not appropriate since you need to alert or alarm your fellow staff and the fire department,” he says. “But by training, staff should call out their facility’s code word for a fire . . . as they are rescuing those in immediate danger.”

After calling out the code word and rescuing people, you would proceed to the “A” and alarm the building. “Hopefully this can be done by another staff member” who hears the code word called out, Birk suggests.

He adds that in his experiences as a former fire investigator, too many times employees assume that someone has already pulled a building alarm during a fire.

“When your staff this: You can’t activate the fire alarm system too many times,” Birk says. “If in doubt, trip another manual pull station.”

**JCAHO focuses on patient safety, not RACE**

Word from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and from those in the health care field indicates that JCAHO surveyors will not emphasize the RACE procedure during accreditation visits.

RACE stands for Rescue, Alarm, Confine, and Extinguish. Some facilities also teach the “E” to stand for Evacuate.

The JCAHO does not mandate that a health care facility include the RACE procedure in its fire plan, according to Donna Larkin, a media relations specialist with the Joint Commission. The JCAHO looks for the safety of patients, staff members, and visitors to be at the forefront of any response to a fire.

“The very first step the Joint Commission would expect a staff member to take upon discovery of a fire would be to get any patients or others out of harm’s way,” Larkin explains.

Martha Pearce, director of protective services at Albert Einstein Healthcare Network in Philadelphia, PA, says JCAHO surveyors are likely to grill you on how your fire response plan works.

“I cannot recall RACE ever being specifically targeted by the JCAHO,” Pearce says. “However, when staff are questioned about fire safety and respond the way I taught them—in other words using the ‘E’ as extinguish or evacuate depending on the situation—the surveyors have never questioned it.”

“In our past three JCAHO inspections, there has never been any discussion of RACE,” says Gerald Bottomley, CPP, director of safety and security at Good Samaritan Community Healthcare in Puyallup, WA. “We are also scrutinized by the Washington State Department of Health and the city fire marshal. No one has ever raised the question.”

At Sheppard Pratt Health Systems in Baltimore, MD, a recently completed JCAHO survey also yielded no difficulties when it came to RACE.

“The surveyor didn’t ask us about RACE but was concerned about the process” in response to discovering a fire, says Tom Jeffers, safety manager at Sheppard Pratt.
**Questions & Answers**

**Q:** A surveyor cited us for having a waiting area that exceeded the maximum size permitted by the Life Safety Code (LSC). The design is unique in that the waiting area is made up of two areas opposite each other with the corridor passing between them. This arrangement made the two waiting spaces appear as one so the patients and visitors got the sense of one large area, instead of two small cramped areas.

The surveyor noted that one space was about 500 square feet and that the other space was about 400 square feet, so the total area exceeded the 600 square-foot limit permitted by exception 7 to paragraph 13-3.6.1 in the LSC. We thought we could evaluate the areas separately since there is no code limit on the number of waiting rooms, but the surveyor said they were so close that we had to consider it as one space. Is our arrangement permissible?

**A:** We think your arrangement is acceptable based on what you described, but only for existing construction.

Although section 13-3.6 of the LSC is not clear on how to evaluate separate waiting areas, there is an appendix note to exception 7 of 13-3.6.1 that answers the question.

The appendix note states: “This would allow waiting areas located across the corridor from each other, provided neither area exceeds the 600 square-foot area limitation.”

Note that the appendix, which applies to existing construction, indicates each area cannot exceed 600 square feet, not the aggregate area.

However, in exception 2 to 12-3.6.1, you will see that new construction does limit the aggregate area, so your arrangement would be prohibited in new construction since the aggregate area is more than 600 square feet.

It is also worth noting that you can have waiting areas in excess of 600 square feet as long as they comply with exceptions 1 or 6 of 13-3.6.1 (see 12-3.6 for new construction). Exception 2 of 13-3.6.1 may also help you with your situation.

**Q:** When discussing means of egress requirements, what exactly does the Life Safety Code (LSC) mean when it refers to a “public way”?

**A:** When the LSC refers to a public way, it usually means a street that is owned and maintained by the local government—in other words, the road is “publicly owned.”

In Chapter 3, “Definitions,” the LSC states that a public way is “any street, alley, or other similar parcel of land essentially open to the outside air deeded, dedicated, or otherwise permanently appropriated to the public for public use and having a clear width and height of not less than 10 feet.”

A means of egress is a continuous path of travel from any point in the health care facility to a public way.

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*Questions, anyone?*

If you have a question about life safety compliance, fire codes and standards, or fire safety, pass it along to us and we will include it in one of Healthcare Life Safety Compliance’s future questions and answers columns.

You can mail your questions to: Healthcare Life Safety Compliance, P.O. Box 1168, Marblehead, MA 01945.

Or, if you prefer, you can fax us your questions at 781/639-2982. Please put your fax to the attention of Healthcare Life Safety Compliance.
According to the LSC, there are three parts to means of egress: the exit access, the exit itself, and the exit discharge.

The exit discharge is defined as “the portion of a mean of egress between the termination of an exit and a public way.”

Under section 5-7.1, the LSC requires that all exits end directly at a public way or an exterior exit discharge.

“The yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way,” the LSC states. That point is an important one. A sidewalk outside the facility’s door, or an area such as a lawn or parking lot, is not the public way, so a hospital must provide safe access through those areas to the street. The LSC doesn’t require sidewalks.

According to the LSC, there are three parts to means of egress: the exit access, the exit itself, and the exit discharge.

In a large, campus-type facility where the public way is a long distance from buildings, you may need to work out a reasonable solution with your local authorities.

There are some exceptions under 5-7.1 for interior exit and rooftop exit discharges. See Chapter 5, “Means of Egress,” for full details.

In focus . . .

Lab employees and clothing fires

With flammable hazards in many clinical laboratories, employees must be ready to deal with a situation where someone’s clothing catches fire.

NFPA standards contain recommended emergency procedures for extinguishing clothing fires in health care facility labs. While there are no explicit requirements to do so, the Joint Commission on Accreditation of Healthcare Organizations expects labs to use NFPA 99 where appropriate.

Chapter 10 of NFPA 99, “Laboratories,” contains the requirement for having a policy for putting out clothing fires. This policy should be reviewed with employees at least annually.

It’s up to individual lab safety officers to determine their policies, but NFPA 99 recommends that employees learn the basic “stop, drop, and roll” strategy if their clothing catches fire. Also, if someone sees their colleague on fire, they should immediately knock that person to the ground and roll the person around to help smother the flames. Keeping a person prone also prevents flames and gas from rising up someone’s body to his or her face. An important point: Don’t run if you catch fire because running can fan flames and increase the size of a fire, according to the NFPA.

The NFPA believes safety showers and fire blankets are of secondary importance when someone is on fire and they should only be used when they are immediately at hand. The NFPA and life safety experts caution that fire blankets are dangerous if used improperly. For instance, if you wrap someone who’s standing up in a fire blanket, the blanket can act as a chimney and send hot gases to the victim’s face.

In its Health Care Facilities Handbook, the NFPA says that if you use a fire blanket on someone whose clothing is on fire, “bring the blanket across the victim from head toward feet (pushing flames and toxic gases away from the face) to smother flames.” Once the fire is out, remove the blanket immediately to avoid trapping heat from smoldering clothing.
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