MHA
Respect · Integrity · Compassion

Annual Fire Safety & Emergency Procedures Refresher Training

(estimated 45 – 60 minute active discussion led by Fire Safety Officer)

Date: ______________________

Presenter: ______________________________

Topics Covered:

- Review of fire drill procedures & documentation, evacuation routes, and meeting places
- Contingency evacuation / relocation plans for DDS or DMH
- Review of recent fire drills in the house – how did they go? Concerns? Things that went well?
- Fire extinguishers, smoke & carbon monoxide detectors – locations, reporting problems to APG
- General hazards – interior of house / exterior of house. It is EVERYONE'S responsibility to report and immediately correct concerns. Any recent issues?
- Kitchen Fire Safety – never leave cooking unattended, monitor participants while cooking, stove, oven, & microwave fires
- Electrical Fire Safety - no extension cords, space heaters used in emergencies only, power outlets are not overcrowded
- Dryer use expectations – LINT!
- Smoking expectations
- No candles or deep fryers
- Location of emergency phone numbers and on-call system expectations
- Review of Medical Protocol & Emergency Response sheet
- Other areas covered ____

Persons Attending:

Name (print)	Signature	Program

In March 2009 there was a fire in a Wells, New York group home where 9 developmentally disabled adults resided. The home was state-of-the-art and only nine-months old. The grand jury report found that staff at the facility had falsified fire drill records; instead of taking residents out of the home and to the designated meeting spot during fire drills, staff simply escorted them to the front foyer of the house then allowed them to return to the living areas. Apparently, this is what the residents became used to doing. During the actual fire, the two staff on-duty were busy trying to assist a resident who had fallen while they were trying to evacuate. Four residents heard the alarm, went to the front foyer, did not see staff, and returned to the living areas, as they had done during the drills. The four individuals became trapped & perished in the fire. The house burnt to the ground.

COOKING FIRES

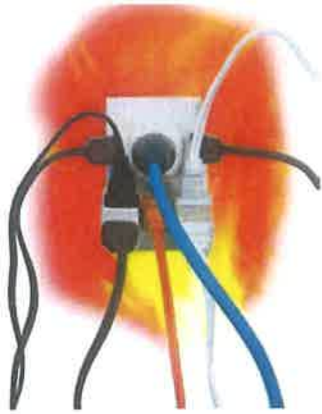
Cooking is the #1 cause of home fires. In 2013, there were 9,946 fires in MA because of cooking. These resulted in 6 deaths & 66 injuries to civilians, and 26 firefighter injuries. Total damages were $9.8 million. The majority of injuries resulted from people trying to fight the fire. Call 911 and get out. Leave firefighting to the pros!

Don't disable smoke detectors while cooking if a 'nuisance' alarm happens. Instead, relocate the detector or install a photoelectric one.

Test & vacuum smoke detectors monthly. Change batteries twice a year when clocks are set.

Cooking Safety Tips

- Stand by your pan!
- Don't leave cooking food, grease, or oils unattended. This is the leading cause of kitchen fires.
- Put a lid on a grease fire! This is the safest way to put it out. Keep a lid or a baking sheet nearby to smother the fire (baking soda works too). Turn off the heat. Never move a burning pan – you can get burned or the fire can quickly spread.
- Never use water or a fire extinguisher on a grease fire! Water or the force of the extinguisher can splash the flaming grease and spread it.
- Never wear loose fitting or flowing clothing while cooking! If clothes do catch fire, Stop, Drop, & Roll to put out flames. Cool burns with running water and call 911.
- Always keep pot handles turned inward on the stove!
- Make sure that all pot holders, towels, paper or plastic is away from heating elements!
- For a fire inside an oven or microwave, turn off the appliance, unplug if you can, and keep the door closed. Call 911. Metal, utensils, aluminum foil, and twist ties can cause fires in microwaves.
- Unplug appliances such as toasters and coffeepots when not in use.
- Never store items in an oven.
- Many of our participants enjoy cooking but should be assisted and/or monitored.



HOME ELECTRICAL FIRES

Between 2009 - 2013, there were 2,700 Massachusetts home fires caused by electrical problems. These fires caused 35 deaths to civilians, 1 firefighter death, 138 civilian injuries, 311 injuries to firefighters, and $122.6 million in loss. Electrical fires were the second leading cause of fire in 2012 & 2013.

Call 911 immediately for any of these warning signs:

- Arcs, sparks, or short circuits
- Sizzling or buzzing sound
- Odors, vague smell of something burning

Call a licensed electrician ASAP for any of these warning signs:

- Frequently blown fuses or tripped circuit breakers
- Dim or flickering lights or bulbs that wear out too fast
- Overheated plugs, cords, or switches
- Shock or mild tingle; more than normal static electricity
- Loose plugs
- Faulty outlets or switches

The plugs on **extension cords** are the places where heat builds up. They should never be used as a permanent fix because they don't have the same safety features (like fuses or circuit breakers) that wall sockets have. Most extension cords do not have enough electrical current to safely support a space heater, an air conditioner, and many other appliances and electrical items.

Look around your home and correct any of these problems:

- Overloaded outlets
- Cords pinched behind furniture like couches or bureaus
- Overloaded power strips
- Lamps with lightbulbs higher than the recommended wattage
- Electrical cords beneath rugs, carpet, or furniture
- Cords with frayed wire or cracked insulation
- Cords that are nailed into place – this can cause electrical shorts and arcing

DRYER FIRES

Another leading cause of home fires is the dryer. Tips include:

- Clean the filter screen after each use. Lint can cause clogs, overheating and fire
- Wash the filter screen with warm soapy water every 6 months. Leftover chemicals from dryer sheets can cause clogs, overheating, and fire
- Never leave the dryer running when you are not home
- Clean out accumulated dust and lint in the hose pipe that vents to the outdoors twice a year with a vacuum cleaner
- Don't put mop heads in the dryer – cleaning chemical residue can cause a fire
- Don't leave clothing or other combustibles close to the dryer

A Successful Fire Drill:

- Is a surprise
- Requires everyone to evacuate in under 2 ½ minutes
- Has at least one blocked exit
- Should be done at different times of day & night
- Requires everyone to go to the meeting place
- Has staff closing doors whenever possible
- Is properly documented

Mental Health Association, Inc.

Fire Drill Procedure

1. Each program will create an evacuation binder.

2. Each residential program will have a written evacuation procedure that identifies the actions staff should take in the event of a fire. Included in this will be the "meet location".

3. Annually or as needed, staff should review the evacuation plan for their assigned residential program. In addition, staff are required to have an annual fire safety training.

4. Per funding regulations, programs will conduct quarterly fire drills. There will be 2 asleep drills and 2 awake drills annually. YIT programs will have monthly fire drills.

5. Fire drill results will be documented in writing using the appropriate form utilized by funding source.

6. The time it takes to evacuate a site will be documented for each participant.

7. Every program has a fire safety officer assigned

8. It is recommended that when possible the Fire Safety Officer, in conjunction with the Supervisor, conduct but do not take part in the fire drill. If they are not available the staff on duty will conduct the drill. There should be a minimum of participation in the evacuation by the person conducting the drill.

9. All drills will be unannounced to both staff and participants.

10. It is expected that the "fire" will be located in different areas of the house if possible

11. If a participant fails to evacuate in the defined 2.5 minutes this information should be sent to the Director of Quality Improvement and the Division Vice Presidents immediately.
    a. A new drill will be held ASAP (usually the following day).
    b. If there is a 2nd fail A plan of action to address the cause of the failure will be written and sent to the President & CEO, the Division Vice President, the Program Director as well as the Director of Quality Improvement.
    c. The drill will then be repeated ASAP (usually the following day).
    d. If a program fails to evacuate again there must be a plan put in place immediately to ensure all participants can exit safely. This plan will stay in effect until a drill can be successfully demonstrated.
    e. For DDS residential programs, the Area Office needs to be notified of failure and actions taken by MHA. MHA may request a consultation from QUEST (DDS) to develop an acceptable plan. Any changes in the evacuation procedure needs to be documented on the evacuation plan for that site and resubmitted to the DDS Area Office for approval.

12. The actual alarm system should be activated to ensure the participants are familiar with its sound and to ensure the horns and/or strobes are operating properly.

MHA

MEDICAL PROTOCOL & EMERGENCY RESPONSE

When dealing with a medical emergency, never hesitate to call 911. Careful observation and timely reporting is critical in responding to our clients' needs in the event of an emergency or illness.

Life threatening emergencies; call 911 and follow First Aid/CPR procedures while waiting for help:

- Unconscious, not responding
- No pulse
- Not breathing or extreme difficulty breathing
- Bleeding that cannot be controlled by direct pressure
- Chest pain or pressure
- Major changes in mental status (disorientation)
- Loss of muscular coordination
- Inability to walk
- Inability to speak or changes in speech (slurred, garbled)
- Drooping of the face (usually mouth)
- Arm weakness
- Any unwitnessed fall or head injury
- Administration of an Epi-pen
- First known seizure
- Broken bone larger than arm or any open fracture
- Vomiting blood or coffee-ground like substance

When injuries are **not** life threatening but require emergency room treatment, a determination must be made regarding transporting the client by calling 911 or by staff or program vehicle. When in doubt, call 911.

Non-emergency medical care; call the program nurse first (during business hours). If after hours, call the client's PCP and notify the Division-on-Call. Examples of non-emergency situations include:

- Cold or flu symptoms, fever, cough
- Nausea, vomiting, diarrhea
- Signs of dehydration (dry skin, dry tongue, decrease in urine output, lethargy)
- Frequent urination, absence of urination for more than 8 hours or pain with urination
- Dizziness
- Headache not relieved by medication
- Increase in seizure activity
- Clients stating they "don't feel well"
- Suspected side effects of medication (tremors, sedation, stiffness etc.)
- Change in eating habits
- Change in mental status
- Constipation
- Bruising
- Pain
- Rash

All medical emergencies and all situations involving a change in a client's health status (medical or psychiatric) will be reported to the program supervisor, program director, and program nurse during MHA business hours. After business hours, the Division-on-Call will be notified and voicemail messages left for the program director, program supervisor, and program nurse.

Documentation: An incident report will be completed following any ER visit or hospitalization. A notation of the incident will be documented in the staff log book and verbally communicated to oncoming staff.

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