Academy of Architecture for Health

Webinar Title: Security Design Guidelines for Healthcare Facilities
Webinar Date: July 13, 2021

Unanswered Attendee Questions with Responses

Q: Can I obtain a copy of the presentation?
A: You may download a PDF of the presentation and resources in the handout section and at https://bit.ly/AAH21LC06

Q: How do you keep guns out of the facility even people with Concealed Carry Permits?
A: Each state has their own gun laws that dictate what HCFs can do in terms of policy / restricting them from the buildings or campus. However, we can reduce the opportunity for weapons using signage and metal screening. Typically, this is happening in some Emergency Departments and locked behavioral health units. The SVA will help determine the need for metal screening.

Q: Should security consultants be onboarded prior to the design phase for healthcare facilities?
A: Yes. Usually this should begin when you conduct the required Safety Risk Assessment. From page 5 of the Guidelines, *"In all renovation or new construction projects a security vulnerability assessment should be led by a qualified healthcare security professional who should also be a member of the project design team."*

Q: I wanted to ask a question about the slide with the light fixture on the pole. What was the issue with the fixture?
A: Ha, sorry about that. The solar cell quit working and the original lighting on the site was still not working either. Resulted in a dark parking lot… It could have been an OK temporary fix, but let's fix the original lighting failure…

Q: Should all visitors go thru a metal detector?
A: Depends on the Security Vulnerability Assessment (SVA).

Q: What are the statistics for patients which are violent to the staff? Are there any?
A: Click here for a U.S. Bureau of Labor Statistics factsheet on Workplace Violence in Healthcare

Q: Should each Nurses' Station have an alarm button to notify security without needing to dial the Security office?
A: Depends on the SVA. Typically, these are in Emergency Departments, Behavioral Health, Pharmacies, Cashier offices etc… The IAHSS has an operational guideline on this topic. Click here. Panic Buttons and Duress Alarms are defined in the guidelines.

> ***Panic Alarm:*** *An activation device placed overtly and accessible which is intended for security situations where silent notification is not required. Typical locations include ICU, Behavioral Health, ED, and parking areas. From page 10 of the SDGHF.*
> ***Duress Alarm:*** *An activation device placed covertly and accessible which is intended for security situations where silent notification is appropriate. Typical locations include cash handling areas, pharmacy, reception, and Administration. From page 9 of SDGHF.*

Q: Many of our clients are moving toward self-service check-ins either via kiosk or mobile app, and then self-navigate to waiting areas and departments. What trends for safety of staff and patients do you see in these public areas where fewer employees are often present? Do technology systems ever fully replace actual eyes on the space?
A: This is probably an area of debate. I am a fan of these systems. However, they must be supplemented with eyes on staff. The SVA will help dictate the degree of security needed at each facility. The self-serve devices help speed up the process. But final access can be approved by staff.

Q: Would the fact that the one door needs to be closed before the other is open be considered "special knowledge" and therefore a code problem for the elopement buffer?
A: Installations with elopement buffers (man traps) are most often approved by the AHJ under special locking configuration requirements. Click here for an article on this topic.

Q: What are you seeing with Pharmacies and security updates?
A: In the last ten years there has been much progress made in the automated systems that monitor potential drug diversion based on volume and individual distribution per nursing unit or area. However, we still need to keep in mind the traditional physical security elements when designing pharmacies. Internal theft and armed robbery are still risks that need to be evaluated and designs included to reduce those risks. The pharmacy design guidelines with the SDGHF provide detailed elements to consider.

Q: "What is the one architectural planning item for Safety that should be done no matter what"
A: The initial planning phase of BMH patient care settings should include a security vulnerability assessment led by a qualified healthcare security professional.
From page 11 of the SDGHF.

> *"**Qualified Healthcare Security Professional:** A person who, by possession of a recognized degree, certificate, professional standing, or skill, and who, by knowledge, training, and experience, has demonstrated the ability to perform the work. A qualified healthcare security professional may be a Certified Healthcare Protection Professional or one with healthcare specific security expertise and certification such as, Certified CPTED Practitioner or Certified Protection Professional with healthcare specific security expertise."*

Q: Has Covid-19 really sent some folks over the edge, a paranoia state, raising to a higher incident of healthcare violence
A: I will probably get some dissenting opinions here, but it appears Covid has overall reduced the number of incidents due to the restriction in the number of visitors. I am waiting for some research on this one. The IAHSS does an annual crime study, and we will know more this fall when the study is completed.

Q: How do code requirements pertaining to electronic locksets in series relate to elopement buffers, if the elopement buffer is part of a required means of egress?
A: Installations with elopement buffers (man traps) are most often approved by the AHJ under special locking configuration requirements. Click here for an article on this topic.

Q: One thing we struggle with is Door Sequencing of Automatic Doors? So many times, we fight the convenience over security argument. Is this something that can be clarified in upcoming revisions of the guidelines if possible?
A: I would like to think this issue could be addressed with a risk assessment with the departments involved. My own opinion is the auto doors should be closing in 12 seconds or less. A door-by-door review and a security awareness program can go a long way toward helping reduce this risk. Consider development of a "DON'T HOLD THE DOOR" employee awareness program to reduce the potential for unauthorized access to security sensitive areas. Click here for an example of this type of program.

Q: Has FGI adopted the Security Guidelines as a reference standard?
A: FGI references the guidelines. They are not standards.