



IAHSS SECURITY DESIGN GUIDELINES FOR HEALTHCARE FACILITIES (2020)

DRAFT GUIDANCE DOCUMENT

ALTERNATE CARE SITES – MEDICAL SURGE CAPACITY

STATEMENT:

Alternate care sites (ACS), or other temporary or re-purposed sites established to provide medical surge capacity for the influx of patients, should be designed to facilitate the delivery of care and protect the privacy, dignity and health of patients, while creating a safe and secure environment. The availability of ACS space and the type provided may limit the applicability of the intents below but, in all cases, they should be considered in design and during implementation.

GLOSSARY OF TERMS:

Alternate Care Sites: are facilities that are temporarily constructed or converted for healthcare use during a public health emergency to reduce the burden on hospitals and established medical facilities. Typically, these are locations for patients who require some degree of medical care and may provide a higher level of monitoring required for patients than in isolation sites. [Centers for Disease Control and Prevention]

Isolation Sites: where a patient can remain for the duration of their isolation period. Typically, this is temporary housing for a cohort of patients who do not need medical attention but who cannot stay at home. Patients in this type of facility require limited monitoring and can care for themselves. These facilities have limited medical staff on hand and do not provide the level of care available at an acute care hospital. Examples include patients housed in a dedicated hotel or dormitory established or reconfigured for this purpose (in their own rooms with their own bathrooms). [Centers for Disease Control and Prevention]

Medical Surge Capacity: Refers to the ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds normal operating capacity. The surge requirements may extend beyond direct patient care to include such tasks as extensive laboratory studies or epidemiological investigations. [U.S. Dept. of Health & Human Services, Public Health Emergency]

INTENT:

- a. The IAHSS Security Design Guidance for Alternate Care Sites - Medical Surge Capacity is intended to provide guidance to healthcare security practitioners, design teams, clinicians and building owner representatives involved in the design and implementation process. These best practices may be considered and integrated, where appropriate, into each new, re-purposed or renovated space for the delivery of healthcare services. This guidance document relates to physical security and is not intended to address cyber or data related security concerns.

- b. This guidance document complements the Security Design Guidelines for Healthcare Facilities, General Guideline, Parking and External Campus Environment Guideline #01, Buildings and the Internal Environment Guideline #02, Areas with Protected Health Information Guideline #02.07, Utility, Mechanical, and Infrastructure Areas Guideline 02.08, and the Emergency Management Guideline #04.
- c. The initial planning phase for an ACS should include a security vulnerability assessment led by a qualified healthcare security professional with key facility stakeholders engaged in the process.
- d. The project design team should, when possible, incorporate the design into the existing security plan indicating a layered approach which may include zones, control points, circulation routes, and required egress paths. Designs should, when appropriate, utilize existing security features (access points, security and video management systems) and should incorporate existing building technology systems. This guidance is provided recognizing an ACS may be a temporary building, be in a remote area or have minimal, or no security technology or traditional security hardware in place.
- e. The design of an ACS should be flexible and adaptable to address changes related to expected surge capacity needs. Factors impacting the design and activation of an ACS include patient type, level of care, facility type as well as age, mobility, complexity of required care and risks presented to the patient or others. The level of security may vary based on these factors, the environment the ACS is located within and the physical features of the facility.
- f. Establish a clearly defined perimeter to best monitor and manage access into and egress from the ACS and balance such concerns with the clinical needs of the facility. When and where deemed appropriate and in consideration of internal and environmental risk and design options available, the following perimeter security design elements should be considered:
 1. The ACS should be accessible to at least two roadways to provide continuous access in the event one becomes blocked or inaccessible.
 2. Fencing or other similar types of barrier designed to control external grounds and roof access should be considered. Given that the introduction of an ACS may be based on an immediate need and may not be a permanent physical structure, special attention should be paid to securing and monitoring the perimeter of the facility.
 3. Adequate parking for staff and other vehicles, EMT access, ambulance drop off and pick up should be considered.
 4. Install locking hardware to restrict and control access to all entry and egress doors to the facility, where they exist. The number of secured entrances and exits should be limited. Consider one primary entry and exit from the facility for patients, with a separate secured entry for staff and EMT.
 - i. Design patient 'drop-off' points with alternative walk-in access points that can be used to screen potentially contaminated patients. Consider a design that funnels those entering the facility through a dedicated medical screening area allowing for enough room for multiple screening stations. Establish "social distancing" parameters are met if necessary and design entry so it can be scaled up or down based on need.

- ii. Apply the same social distancing guidance to areas assigned for staff entry and egress as well as other perimeter points such as equipment or materials transfer areas.
 - iii. Equip employee/staff access points with methods for identifying those utilizing such areas include staff-keyed hardware and a clearly marked communication station on the exterior side of the entrance with direct visual observation capability or a video surveillance system to manage the control system.
 - iv. Equip each perimeter exit area with a means of alerting in the event of intrusion including hold-open alarms that enunciate locally for staff monitoring and remotely to another 24/7 attended location. Consider providing staff portable devices that can be worn and receive such alarms.
 - v. When the ACS may be a temporary tent-like space or other design that would render the use of security hardware and electronics unfeasible, the use of security or other staff to accomplish the objectives of this Intent should be considered based on the security vulnerability assessment.
5. The design should support the ability of the ACS to promptly evacuate, lock down, and shelter-in-place. This should include the ability to quickly manage the environment, including:
- i. Lock down the ACS and isolate all access and egress to select locations, either through hardware, technology, personnel or some combination.
 - ii. Manage air intakes to the degree possible so that they can be shut off immediately when necessary.
 - iii. Control air circulation, where applicable, by management of heating, ventilation, and air conditioning and related filtration systems in the event of an emergency that requires the isolation of areas, purging of the system, or reversal of air flow.
 - iv. Control water distribution throughout the ACS.
6. Deploy video surveillance, even on a temporary basis, to capture and record images of the facility perimeter to include all persons entering and exiting the ACS.
- i. Other applications of video surveillance should be determined by the security vulnerability assessment.
 - ii. Security or administrative staff should have ready access to surveillance images and be trained in system operation.
- g. The internal environment of an ACS should be for authorized staff-only and designed in consideration of the following elements:
- 1. Provide clear directions on appropriate pathways to and from patient care and support areas.
 - 2. Secure and restrict access to staff-only areas and where appropriate, elevators, stairwells, mechanical space, areas housing medical supplies, hazardous materials, equipment and other such areas.
 - 3. Where and when applicable, utilize hardware on internal stairwells to restrict and control access in accordance with applicable building and fire codes including the equipping of doors with authorized staff-keyed hardware. Alarms should

- enunciate locally for staff monitoring and remotely to another 24/7 attended location if possible.
4. Deploy video surveillance to capture and record images in public areas and circulation routes within the facility. Images should be of sufficient quality to allow staff to readily identify individuals.
 5. Ground floor windows, where they exist, should be designed to prevent unauthorized access into or exit from the facility based on the security vulnerability assessment.
 6. Exterior windows or other such openings, if applicable, located throughout the ACS should be treated to prevent internal viewing from outside of the facility.
- h. Other areas related to the ACS environment that may require security attention:
1. Dedicated space for patient triage with clear distinction between triage and the waiting area(s). The line of sight between triage workstations and the patient entry should not be disrupted. Triage access should be controlled with two points of entry/exit for staff. Care provider workstation(s) should be positioned to provide direct access to an exit portal (safe drop-back zone) and equipped with strategically located duress alarms.
 2. Staff respite area separate from patient care area, and when possible, with a bathroom for staff use only and staff can store personal belongings, take breaks, and eat. If available, access to staff lockers and lounges should be controlled and restricted to authorized staff only. Locked storage or other means of control should be provided for clean and soiled staff uniforms.
 3. Dedicated area for staff to put on and remove personal protective equipment (PPE).
 4. Patient care area or rooms with access to patient bathrooms/shower areas. Consideration should be given to patient spaces that may also be utilized, even on a temporary or short-term basis, for the care of behavioral/mental health (BMH) patients. Design and operational guidelines associated with BMH patients should be reviewed and risk mitigation measures considered for identified vulnerabilities.
 5. An area or areas where staff can document and monitor patients. Where feasible, patient care locations should be observable from the designated area, with video surveillance and convex mirrors deployed, as necessary to achieve this.
 - i. Beyond security, the surveillance system may be used to assist staff to reduce patient contact.
 6. Restricted and controlled area(s) for medication storage/preparation. The layout should provide designated space for medication preparation activities that are not in the immediate patient care area and away from potential sources of contamination (e.g. sink)
 7. Secure storage or other secure means for storing controlled substances and items of higher value (e.g., surgical instruments, PPE). Deploy video surveillance to capture and record images of each area.
 8. Dedicated space for registration and family waiting area where appropriate and when possible.
 9. Restricted and controlled area for storage of clean supplies.
 10. Restricted and controlled area for dirty utility/dirty storage and hazardous

materials with space for medical and non-medical waste and dirty equipment waiting to be reprocessed. Sharps containers should be secured and located near the point of use.

11. Shipping & receiving areas that restrict and control access in and out of the area. This should include secure storage (e.g. fencing, gates, or locked cages for items of higher value, hazardous materials, or items with personal health information).
12. Restricted and controlled area to stage the deceased (body holding room).
13. Restricted and controlled access into kitchen facilities and related storage where they exist.
14. Restricted and controlled access into any support area for laundry and general supplies.
15. Restricted and controlled access for medical gas storage.
16. Security officer /public safety workstations, if applicable, should be located to maximize visibility at patient entry points into triage space to the extent possible.
17. Restricted and controlled access into the central incident command center.

REFERENCES / GENERAL INFORMATION:

Guidelines for Design and Construction of Hospitals 2018 edition, The Facilities Guidelines Institute, <https://fgguidelines.org/guidelines-main/>

Centers for Medicare & Medicaid Services, Conditions for Coverage & Conditions of Participations, <https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/>

Alternate Care Sites (ACS), US Army Corps of Engineers, <https://www.usace.army.mil/Coronavirus/Alternate-Care-Sites/external%20icon/>

Alternate Care Sites and Isolation Sites, Centers for Disease Control and Prevention, <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/alternative-care-sites.html>

California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies, Volume II: Government-Authorized Alternate Care Sites, California Department of Public Health, http://www.cidrap.umn.edu/sites/default/files/public/php/258/258_acs.pdf

SEE ALSO:

IAHSS Healthcare Security Industry Guidelines: <https://www.iahss.org/page/guidelines>

FEEDBACK NEEDED:

This document is a DRAFT Guidance Document on Alternate Care Sites – Medical Surge Capacity. Please submit comments, edits and feedback to info@iahss.org.