



COMMUNITY
SECURITY SERVICES

2015

Security Risk Assessment



Security Services
Community Regional Medical Center
12/31/2015

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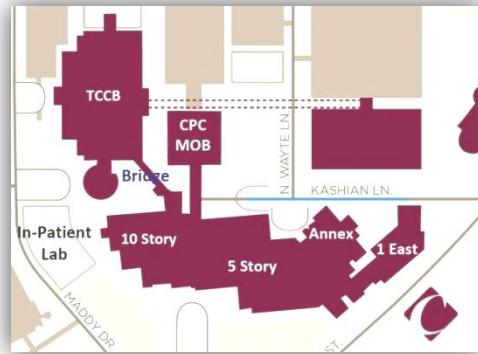
Authors

Victor Allen, Director
Security and Safety Services
Community Regional Medical Center

Chad McPherson, Security Investigations & Safety
Security and Safety Services
Community Regional Medical Center

Executive Summary

Community Regional Medical Center is comprised of a number of buildings representing nearly a century of healthcare design concepts. Architecturally, the facility was designed to be open and accessible to the public, with many entrances, rooms and a variety of people - patients, visitors, staff and vendors - with a need to move about freely. While these design attributes were no doubt consistent with the prevailing industry and organizational philosophies of the times; they now present significant security challenges.



Many security risk vulnerabilities found in the built environment are attributed to the facility design. In this climate security mitigation strategies are often relegated to finding the “best security solution” to the problem created by the design. The challenge of correcting design flaws often necessitates the allocation of considerable financial resources. Measuring the financial return on investment (ROI) from design improvements which affect a complex and interdependent matrix of quality, patient satisfaction and operational efficiency is difficult. The task is made more difficult because security is like insurance: No one likes to pay for it, but everyone is glad they have it when something does occur.

Analysis and evaluation of environmental risks provides supporting rational for making sure security safeguards are implemented appropriately, based on protecting critical resources, while accepting a calculated degree of risk. It is understood that an asset cannot be protected completely without substantial cost or unduly inhibiting the primary mission of providing efficient and quality patient care. The goal of implementing countermeasures for security risks is to make it difficult for a security breach to occur – to harden the facility target.

A thorough understanding of the threats facing an organization is crucial to determine the type and depth of security safeguards necessary to manage the risk. For example, most communities generally have the same type of criminal activity; the difference is usually in degree. When evaluating the crime risks beyond the campus boundaries, one finds a 3 times higher than average crime rate when compared to the county. Forecasting data indicate that crimes, such as homicide and larceny, will continue to increase over the next five years. Understanding factors such as these helps guide current and future security planning strategies. However, the level of target hardening to be implemented depends on the value of the asset and the organization's tolerance for risk.

It is our belief that the continued and future investment in construction offers the opportunity to remake the facility to better serve patients, families and employees while providing a safe and secure space to meet the needs of today's healthcare environment.

Introduction

Community Regional Medical Center (CRMC) is located on a 58-acre campus in downtown Fresno. CRMC is the flagship of Community Medical Centers' three acute-care facilities, with 641 licensed beds and an average of 617 inpatients a day.

CRMC is home to the region's only comprehensive burn and Level 1 trauma centers, servicing a 15,000 square-mile area between Sacramento and Los Angeles. The campus includes a full-service, 56,000-square-foot emergency department. The trauma center is the busiest in the state with the highest acuity.

Approximately, 6,000 babies are born at CRMC, annually. The 84 bed, Level 3, NICU is one of the largest in California. Providing 24-hour comprehensive labor and delivery services and Level 3 NICU care in one location allows newborns to be kept near their mothers and close to their families.

The campus features a 79,534-square-foot outpatient center which includes a seven days a week urgent care center, servicing adults and children with minor illnesses or injuries. Additionally, a 17,000-square-foot, two-story hospitality house provides a supportive residence for families while their loved ones receive critical care in the hospital.

In addition to its affiliation with the Fresno Heart & Surgical Hospital, CRMC supports other off-campus inpatient services, including a behavioral health center and long term care center, as well as, an outpatient Cancer treatment center.

Finally, CRMC is an academic-affiliated medical center, where more than 300 doctors annually, receive specialized training through the University of California, San Francisco (UCSF), Fresno Medical Education Program.

Site Facts:

Vital numbers		Fiscal year 2013-2014	
Licensed beds	641	Admissions	35,196
Intensive Care (ICU)	78	Emergency Dept. visits	110,600
NICU (Level 3)	84	Surgical procedures	13,653
Burn	10	Inpatient	8,374
Medical/surgical	380	Outpatient	5,279
Rehabilitation	32	Cardiology procedures	109,784
Pediatrics	8	Births	6,013
Obstetrics	49	Meals served	1,976,704
		Inpatient	799,558
		Outpatient	969,321



Security Risk Assessment

Purpose

The purpose of this assessment is to identify and evaluate security risk by the level of protective measures (safeguards) in place to manage an acceptable level of risk.

Scope

The scope of this assessment applies to the campus of Community Regional Medical Center and surrounding area.

Objective

The objective of this assessment was to identify the magnitude of security threat risks, and to identify organizational security exposures so a comprehensive, effective, and cost-justified protection plan can be developed and implemented.

Elements

This risk assessment evaluates the various security layers of protection, to include potential hazards which extend beyond the property boundaries, safeguards at the building perimeters and various internal security elements.

Sources of Security Risk Assessment/Data

- Profile of types of patients served
- Social economic profile of geographical area
- Facility and ground inspections
- Crime statistics
- Past Security Incident Reports
- Review of current industry literature

Process of Assigning Risk

- Risk Levels were expressed in terms of addressing the threat and considering the safeguards already in place, but not necessarily by the prevalence of the risk.
- Risks were assessed in terms of degree of the threat to the organization (Real, Perceived and Potential).
 - Real: Based in past events
 - Perceived: Empirical evidence based
- Potential risks were determined based on the objective assumption that foreseeable criminal act relate directly to the probability of crime.

External Environment: Crime Analysis

The type of neighborhood, together with the associated level and type of crime is an important factor when evaluating security risks to the facility. In addition to police crime statistics and security incident reports, a CAP Index CRIMECAST report was also utilized to identify the risk potential of criminal activity on campus and the surrounding neighborhood.

CAP Index, Inc. is crime risk forecasting service, which uses various analytical tools to objectively measure and analyze crime risk for a specified location. The “CRIMECAST” model is based upon the strong relationship that exists between a neighborhood’s “social disorganization” and the amount of crime that is perpetrated there. Taken together these elements help identify the risk of personal and property crimes for a specified location.



CRIMECAST scores are calculated by correlating a broad array of demographic variables (excluding race, religion and gender) with historical crime data, survey information and other known indicators of crime. This report provides data driven scores that place a given location in context with national, state and county levels of crime risk.

The objective nature of security and police crime statistics, coupled with a CAP Index report, provide evidence-based considerations when assessing the overall risk to the facility. The CAP Index, CRIMECAST Report definitions and the full reported are provided in the following pages.

CRIMECAST Report Description

CRIMECAST Reports

With a detailed, color-coded map and a spreadsheet of risk scores, users can identify potential asset protection concerns surrounding an address. A quick glance at the map shows the site in relation to its environment. The CRIMECAST Scores allow for an in-depth analysis of the overall crime risk.



National	
CRIMECAST CATEGORY	CURRENT 2012
CAP Index	633
Homicide	504
Rape	303
Robbery	724
Aggravated Assault	445
Crimes Against Persons	521
Burglary	102
Larceny	804
Motor Vehicle Theft	428
Crimes Against Property	658
CAP INDEX SCORE	
NATIONAL	
Past – 2000	658
Current – 2012	633
Projected – 2017	677

CRIMECAST Scores

- A The CAP Index Score represents the overall risk of crime at the address.
- CRIMECAST Scores are based on a scale of 0 to 2000, with 0 representing the lowest risk and 2000 the highest – 100 is average.
 - A score of 600 is 6 times higher than average, and a score of 25 indicates that the risk is $\frac{1}{4}$ the average.
 - Each CRIMECAST Report contains 90 risk scores provided for 3 geographic levels and 3 time periods:
 1. **National** scores provide the site's risk in comparison to the entire U.S.
 2. **State** scores compare the site to the average risk of the state in which it resides.
 3. **County** scores compare the site to the average risk of the county in which it resides.
 4. **Past, Current and Projected** risk scores are provided to allow for trending.

CRIMECAST Map

- B Census tracts are outlined in blue. There are over 72,000 census tracts in the United States. Each tract contains several thousand residents with similar socioeconomic characteristics. Every census tract is assigned a numeric risk score and a coinciding risk shading.
- C The site map is color-coded to depict the level of risk within each tract and identify the potential origin of criminal behavior. CAP Index Score ranges are used to assign risk shading similar to that of the green, yellow and red color scheme found on a traffic light.
- D A radius threshold analysis is used to determine a site's overall risk. The inner radius represents 1 mile or a population of 25,000, equaling $\frac{2}{3}$ of the overall score. The outer radius represents 3 miles or a population of 100,000, providing the remaining $\frac{1}{3}$. In addition to the 1:3 methodology shown to the left, a 2:6 methodology is also available. This methodology applies an inner radius of 2 miles or a population of 100,000 and an outer radius of 6 miles or a population of 400,000.

CRIMECAST Scores Description

CRIMECAST Scores

This page contains 90 risk scores provided for 3 geographic levels and 3 time periods.

- A** **National** scores provide the site's risk in comparison to the entire U.S. and are broken down by CRIMECAST Category. **Past**, **Current** and **Projected** risk scores are provided to allow for trending.
- B** **State** scores compare the site to the average risk of the state in which it resides and are broken down by CRIMECAST Category. **Past**, **Current** and **Projected** risk scores are provided to allow for trending.
- C** **County** scores compare the site to the average risk of the county in which it resides and are broken down by CRIMECAST Category. **Past**, **Current** and **Projected** risk scores are provided to allow for trending.
- D** The **National Past**, **Current** and **Projected** risk scores for the CAP Index Score and each CRIMECAST Category are graphed in order to provide a visual representation of the site's risk pattern over an extended period of time.



CRIMECAST Reports

Site Information

Community Medical Center
 2823 Fresno Street
 Fresno, CA 93721

Lat: 36.74406, Long: -119.784472

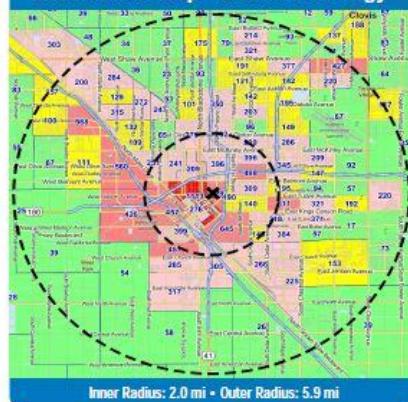
CRIMECAST Scores are based on a scale of 0 to 2000, with 0 representing the lowest risk and 2000 the highest - 100 is average. A score of 600 is 6 times higher than average, and a score of 25 indicates that the risk is 1/4 the average.

CRIMECAST Maps & Scores

CRIMECAST Map - 1:3 Methodology



CRIMECAST Map - 2:6 Methodology



Score Ranges: 0-99 100-199 200-399 400-799 800-2000

FBI Uniform Crime Report (UCR) Data*

CRIME TYPE	2013 COUNTY COUNT**	COUNTY VS. NATIONAL COMPARISON***
Murder	57	1.3
Rape	163	0.5
Robbery	1,221	1.2
Aggravated Assault	3,427	1.6
Crimes Against Persons	4,868	1.4
Burglary	9,102	1.6
Larceny	21,257	1.2
Motor Vehicle Theft	6,339	3.0
Crimes Against Property	36,698	1.4
All Crimes	41,566	1.4

*Refer to the FBI Uniform Crime Report (UCR) Data page for more information.

**Fresno County, CA

***Values above 1.0 exceed the national average.

CRIMECAST CATEGORY	This Site's Scores	
	1:3 CURRENT NATIONAL	2:6 CURRENT NATIONAL
CAP Index	715	643
Homicide	557	502
Rape	546	478
Robbery	740	668
Aggravated Assault	532	498
Crimes Against Persons	614	564
Burglary	390	430
Larceny	609	508
Motor Vehicle Theft	691	733
Crimes Against Property	538	508

Proximity Data

POI CATEGORY	DISTANCE IN MI	POI CATEGORY	DISTANCE IN MI
Bridge/Tunnel	22.1	Bus Station	0.2
Commuter Rail Station	0.5	Court House	0.4
Ferry Terminal	>50	Fire Station	0.8
Hospital	0.0	Marina	3.9
Nuclear Plant	>50	Park & Ride	>50
Police Station	6.8	Port	>50
Shopping	0.8	Sports Complex	0.9
Train Station	0.2		

Please Note: If the distance between the site and a POI is greater than 50.0 miles, the exact distance will not be provided.

Creation Date: November 23, 2015

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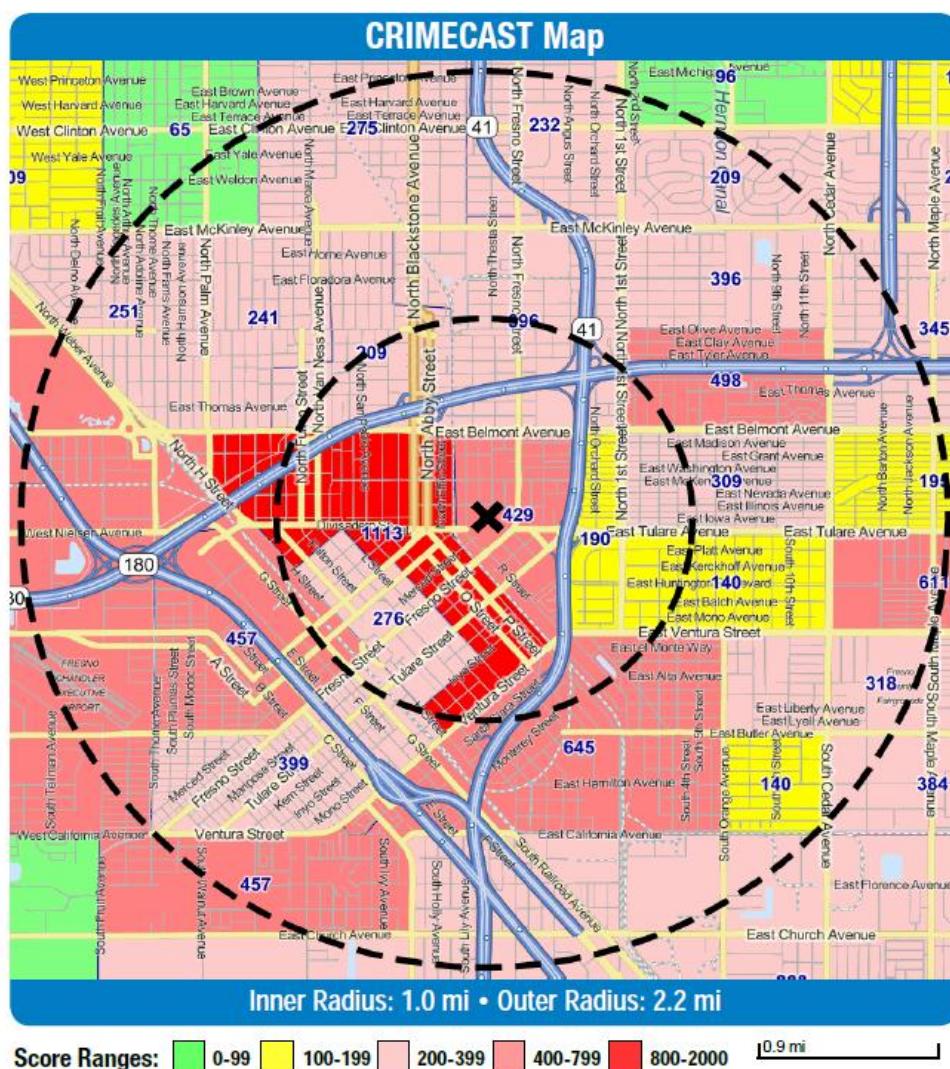
**This site's Current 2015
National CAP Index Score is**

715

Community Medical Center
2823 Fresno Street
Fresno, CA 93721

Lat: 36.74406, Long: -119.784472

CRIMECAST Scores are based on a scale of 0 to 2000, with 0 representing the lowest risk and 2000 the highest - 100 is average. A score of 715 is 7.15 times higher than average.



National

National		This Site's Scores
CRIMECAST CATEGORY	CURRENT 2015	
CAP Index	715	
Homicide	557	
Rape	546	
Robbery	740	
Aggravated Assault	532	
Crimes Against Persons	614	
Burglary	390	
Larceny	609	
Motor Vehicle Theft	691	
Crimes Against Property	538	
CAP INDEX SCORE		NATIONAL
Past - 2010	637	
Current - 2015	715	
Projected - 2020	729	



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1:3 Methodology - CRIMECAST Scores

This site's Current 2015
National CAP Index Score is

715

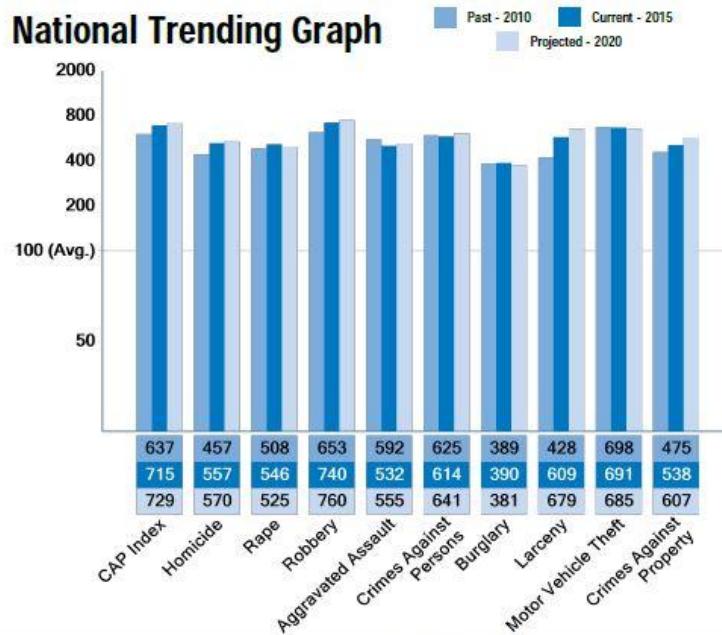
Community Medical Center
2823 Fresno Street
Fresno, CA 93721

Lat: 36.74406, Long: -119.784472

National

CRIMECAST CATEGORY	PAST 2010	This Site's Scores	
	CURRENT 2015	PROJECTED 2020	
CAP Index	637	715	729
Homicide	457	557	570
Rape	508	546	525
Robbery	653	740	760
Aggravated Assault	592	532	555
Crimes Against Persons	625	614	641
Burglary	389	390	381
Larceny	428	609	679
Motor Vehicle Theft	698	691	685
Crimes Against Property	475	538	607

National Trending Graph



CRIMECAST Scores are based on a scale of 0 to 2000, with 0 representing the lowest risk and 2000 the highest - 100 is average. A score of 715 is 7.15 times higher than average.

State

CRIMECAST CATEGORY	PAST 2010	This Site's Scores	
	CURRENT 2015	PROJECTED 2020	
CAP Index	555	601	603
Homicide	486	589	609
Rape	467	496	474
Robbery	555	605	609
Aggravated Assault	563	489	506
Crimes Against Persons	580	550	567
Burglary	546	533	525
Larceny	591	901	1086
Motor Vehicle Theft	340	335	328
Crimes Against Property	552	649	764

County*

CRIMECAST CATEGORY	PAST 2010	This Site's Scores	
	CURRENT 2015	PROJECTED 2020	
CAP Index	433	457	455
Homicide	358	400	423
Rape	423	424	410
Robbery	424	454	453
Aggravated Assault	383	334	334
Crimes Against Persons	413	389	391
Burglary	346	301	290
Larceny	345	481	571
Motor Vehicle Theft	386	344	330
Crimes Against Property	371	392	455

*Fresno County, CA



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This site's Current 2015
National CAP Index Score is

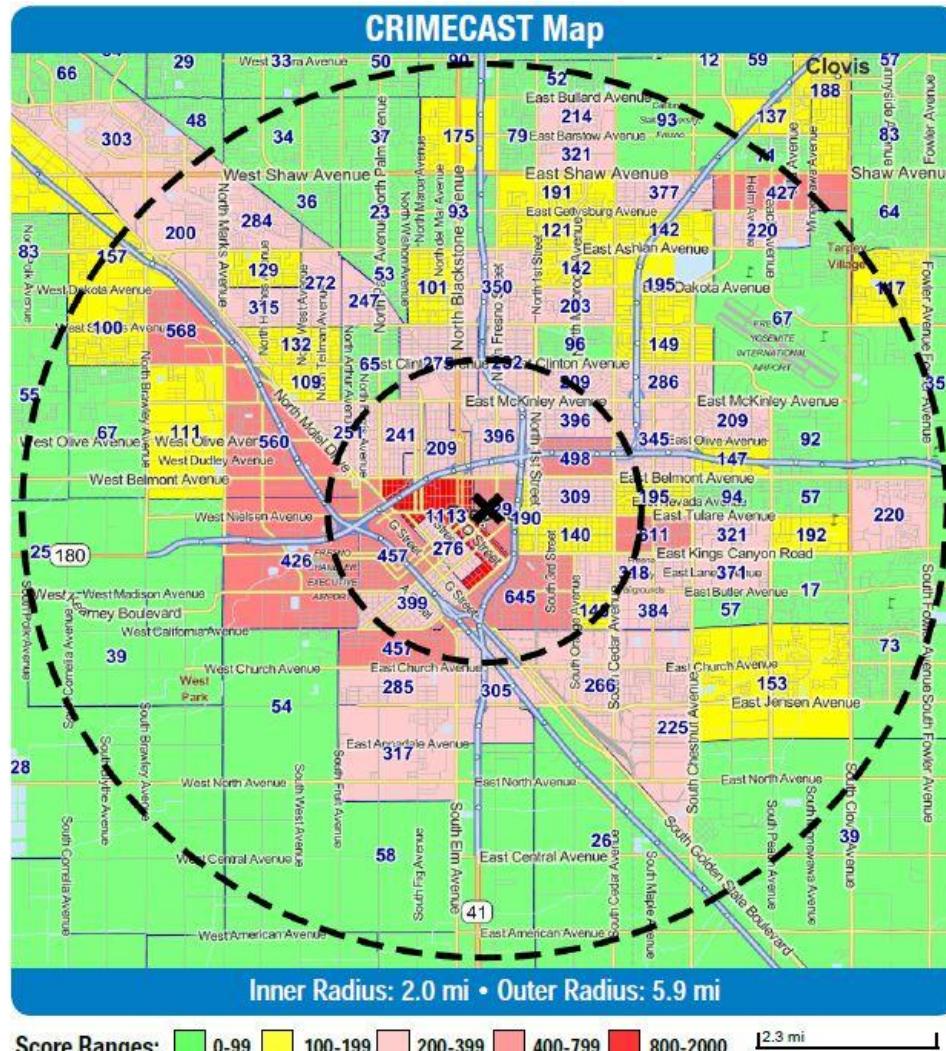
643

Community Medical Center
2823 Fresno Street
Fresno, CA 93721

Lat: 36.74406, Long: -119.784472

CRIMECAST Scores are based on a scale of 0 to 2000, with 0 representing the lowest risk and 2000 the highest - 100 is average. A score of 643 is 6.43 times higher than average.

2:6 Methodology - CRIMECAST Map



National

CRIMECAST CATEGORY	CURRENT 2015	This Site's Scores
CAP Index	643	643
Homicide	502	
Rape	478	
Robbery	668	
Aggravated Assault	498	
Crimes Against Persons	564	
Burglary	430	
Larceny	508	
Motor Vehicle Theft	733	
Crimes Against Property	508	
CAP INDEX SCORE	NATIONAL	
Past - 2010	590	
Current - 2015	643	
Projected - 2020	650	



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2:6 Methodology - CRIMECAST Scores

This site's Current 2015
National CAP Index Score is

643

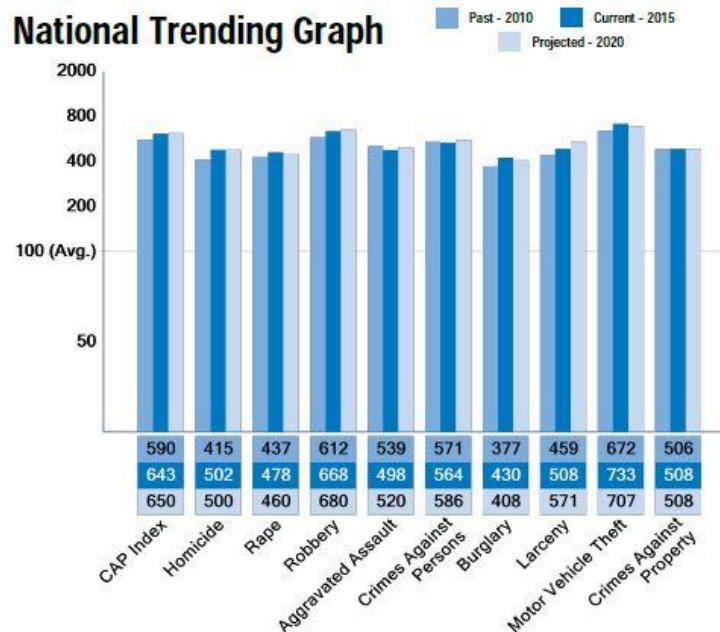
Community Medical Center
2823 Fresno Street
Fresno, CA 93721

Lat: 36.74406, Long: -119.784472

National

CRIMECAST CATEGORY	PAST 2010	This Site's Scores	
	CURRENT 2015	PROJECTED 2020	
CAP Index	590	643	650
Homicide	415	502	500
Rape	437	478	460
Robbery	612	668	680
Aggravated Assault	539	498	520
Crimes Against Persons	571	564	586
Burglary	377	430	408
Larceny	459	508	571
Motor Vehicle Theft	672	733	707
Crimes Against Property	506	508	508

National Trending Graph



CRIMECAST Scores are based on a scale of 0 to 2000, with 0 representing the lowest risk and 2000 the highest - 100 is average. A score of 643 is 6.43 times higher than average.

State

CRIMECAST CATEGORY	PAST 2010	This Site's Scores	
	CURRENT 2015	PROJECTED 2020	
CAP Index	514	541	537
Homicide	442	531	534
Rape	401	434	416
Robbery	520	546	545
Aggravated Assault	513	458	474
Crimes Against Persons	530	505	519
Burglary	529	588	562
Larceny	634	752	913
Motor Vehicle Theft	327	355	339
Crimes Against Property	588	613	639

County*

CRIMECAST CATEGORY	PAST 2010	This Site's Scores	
	CURRENT 2015	PROJECTED 2020	
CAP Index	401	411	405
Homicide	325	361	371
Rape	364	371	359
Robbery	398	410	405
Aggravated Assault	349	312	313
Crimes Against Persons	377	357	357
Burglary	336	332	310
Larceny	370	401	480
Motor Vehicle Theft	372	365	341
Crimes Against Property	395	370	381

*Fresno County, CA



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FBI Uniform Crime Report (UCR) Data

2013 Data for Fresno County, CA

This information is drawn from the FBI's Uniform Crime Report (UCR) Data and is based on the county or state in which the current site is located. CAP Index is not able to vouch for the completeness or accuracy of this information. Nevertheless, our statistical analysis must assume that these data, as recorded and compiled by the various governmental agencies and other sources, are in fact complete and accurate. For more information about the crime categories and data processing methodology, please visit <http://crimecast.capindex.com/usa-ucr.aspx>.

CAP Index utilizes the FBI's Crime by County file to compile UCR information. This file is released during the first quarter of the year following the corresponding online UCR publication.



CRIME TYPE	2013 COUNTY COUNT	COUNTY vs. NATIONAL COMPARISON*
Murder	57	1.3
Rape	163	0.5
Robbery	1,221	1.2
Aggravated Assault	3,427	1.6
Crimes Against Persons	4,868	1.4
Burglary	9,102	1.6
Larceny	21,257	1.2
Motor Vehicle Theft	6,339	3.0
Crimes Against Property	36,698	1.4
All Crimes	41,566	1.4

*Values above 1.0 exceed the national average.

Crimes Against Persons



Crimes Against Property



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Proximity & Population Density

As previously described, the CRIMECAST map radius threshold analysis is useful to determine a site's overall risk. Both methodologies were utilized to identify the risk potential of criminal activity on campus and the surrounding neighborhood.

Crime Proximity:

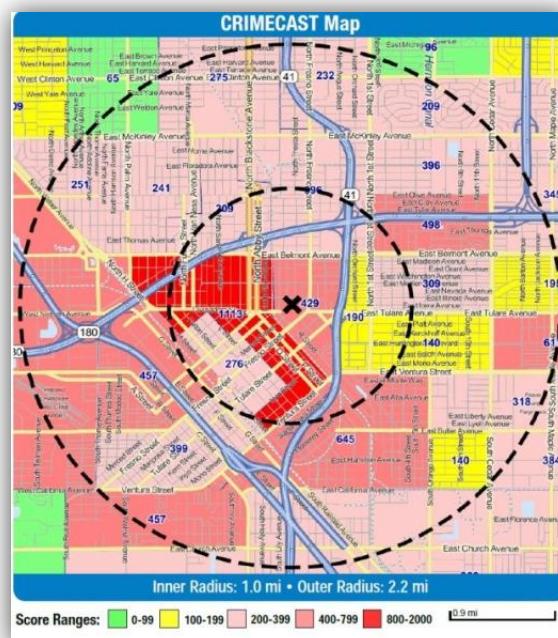
The CRIMECAST 1:3 Methodology produced a score of 457 for CRMC when compared to the county. This means that within a 3 mile radius there is a 4.57 higher than average risk of crime when compared to the rest of the county.

- The inner radius represents either a distance of 1 mile or a population of 25,000, whichever comes first.
- The inner radius accounts for 2/3 of the overall risk score.
- For CRMC the inner radius threshold was reached at a distance of 1 mile.
- Thus we can deduce that within a 1 mile radius of the facility, there is a 3.05 higher crime risk than the average risk for all of Fresno County.



Population Density:

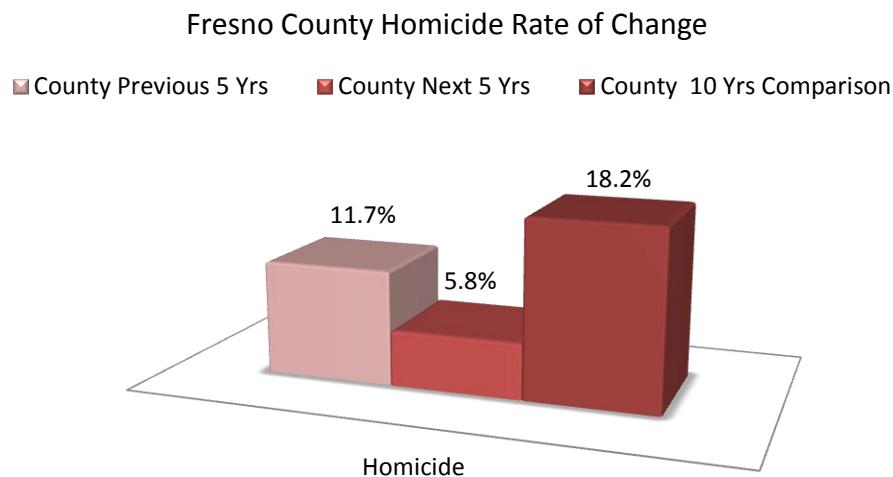
- The outer radius represents a distance of 3 miles or a population of 100,000.
- The outer radius threshold for CRMC was reached at 2.2 miles.
- Thus we can deduce that there are 100,000 people residing within a 2.2 miles radius of CRMC.



Crime Trend Analysis

The rate of change is simply the percentage change in a category between two periods of time. For instance, values above zero indicate upward momentum, while values below zero indicate falling momentum. CRIMECAST crime scores were used to evaluate, not only the direction of a trend but also the momentum. This is noteworthy, because even though a crime growth rate appears to be decelerating, crime may in fact be increasing, although at a slower rate.

For example, using the 1:3 Methodology, Fresno County homicide scores, showed an increase of 11% over the last 5 years. However, in the subsequent 5 years, the growth rate is projected to increase only by 6%. Thus while the growth rate of homicides is projected to slow, homicides are still expected to increase. When you broaden the forecast to include past and future projections, (2010 to 2020) homicides show an increase of 18%.



This data suggests a significant social change in the community. Considering that foreseeable criminal acts have a direct relationship to the probability of crime; it is apparent that the localized community and the “social disorganization” that exists therein, continues to grow and will likely continue to do so, into the foreseeable future.

The data included in the following tables, was taken from the CRIMECAST reports. These tables differ from the CRIMECAST report, in that they calculate rates of change over time. This data includes the CRIMECAST crime category growth rates for the past 5 years, next 5 years and 10 year projections.

1:3 Methodology Change Rate

These tables are based on the CRIMECAST 1:3 Methodology and include rates of changes in comparisons to the Nation, State and County. 5 year change rates are based on current CRIMECAST scores for 2015. The 10 year comparison, is based on the 2010 and 2020 scores. Values in red indicate an increase greater than 2%.

Fresno County	2010	2015	2020	County Past 5 Yrs.	County Projected 5 Yrs.	County 10 Yrs. Comparison
	Past	Current	Projected	% Change	% Change	% Change
Homicide	358	400	423	11.7%	5.8%	18.2%
Rape	423	424	410	0.2%	-3.3%	-3.1%
Robbery	424	454	453	7.1%	-0.2%	6.8%
Aggravated Assault	383	334	334	-12.8%	0.0%	-12.8%
Burglary	346	301	290	-13.0%	-3.7%	-16.2%
Larceny	345	481	571	39.4%	18.7%	65.5%
Motor Vehicle Theft	386	344	330	-10.9%	-4.1%	-14.5%

State	2010	2015	2020	State Past 5 Yrs.	State Projected 5 Yrs.	State 10 Yrs. Comparison
	Past	Current	Projected	% Change	% Change	% Change
Homicide	486	589	609	21.2%	3.4%	25.3%
Rape	467	496	474	6.2%	-4.4%	1.5%
Robbery	555	605	609	9.0%	0.7%	9.7%
Aggravated Assault	563	489	506	-13.1%	3.5%	-10.1%
Burglary	546	533	525	-2.4%	-1.5%	-3.8%
Larceny	591	901	1086	52.5%	20.5%	83.8%
Motor Vehicle Theft	340	335	328	-1.5%	-2.1%	-3.5%

National	2010	2015	2020	Nation Past 5 Yrs.	Nation Projected 5 Yrs.	Nation 10 Yrs. Comparison
	Past	Current	Projected	% Change	% Change	% Change
Homicide	457	557	570	21.9%	2.3%	24.7%
Rape	508	546	525	7.5%	-3.8%	3.3%
Robbery	653	740	760	13.3%	2.7%	16.4%
Aggravated Assault	592	532	555	-10.1%	4.3%	-6.3%
Burglary	389	390	381	0.3%	-2.3%	-2.1%
Larceny	428	609	679	42.3%	11.5%	58.6%
Motor Vehicle Theft	698	691	685	-1.0%	-0.9%	-1.9%

2:6 Methodology Change Rate

These tables are based on the CRIMECAST 2:6 Methodology and include rates of changes in comparisons to the Nation, State and County. 5 year change rates are based on current CRIMECAST scores for 2015. The 10 year comparison, is based on the 2010 and 2020 scores. Values in red indicate an increase greater than 2%.

Fresno County	2010	2015	2020	County Past 5 Yrs.	County Projected 5 Yrs.	County 10 Yrs. Comparison
	Past	Current	Projected	% Change	% Change	% Change
Homicide	325	361	371	11.08%	2.77%	14.15%
Rape	364	371	359	1.92%	-3.23%	-1.37%
Robbery	398	410	405	3.02%	-1.22%	1.76%
Aggravated Assault	349	312	313	-10.60%	0.32%	-10.32%
Burglary	336	332	310	-1.19%	-6.63%	-7.74%
Larceny	370	401	480	8.38%	19.70%	29.73%
Motor Vehicle Theft	372	365	341	-1.88%	-6.58%	-8.33%

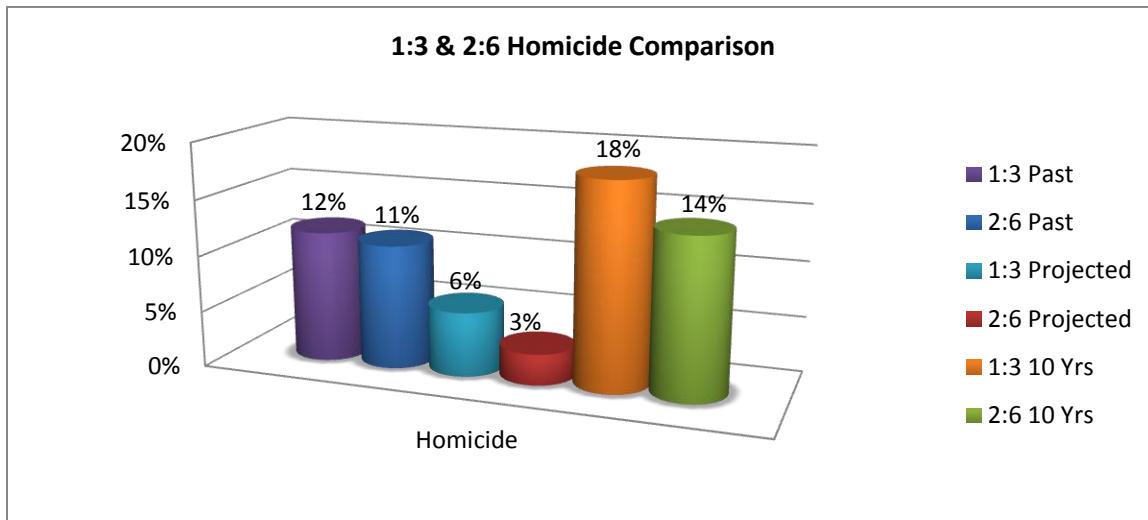
State	2010	2015	2020	State Past 5 Yrs.	State Projected 5 Yrs.	State 10 Yrs. Comparison
	Past	Current	Projected	% Change	% Change	% Change
Homicide	442	531	534	20.14%	0.56%	20.81%
Rape	401	434	416	8.23%	-4.15%	3.74%
Robbery	520	546	545	5.00%	-0.18%	4.81%
Aggravated Assault	513	458	474	-10.72%	3.49%	-7.60%
Burglary	529	588	562	11.15%	-4.42%	6.24%
Larceny	634	752	913	18.61%	21.41%	44.01%
Motor Vehicle Theft	327	355	339	8.56%	-4.51%	3.67%

National	2010	2015	2020	Nation Past 5 Yrs.	Nation Projected 5 Yrs.	Nation 10 Yrs. Comparison
	Past	Current	Projected	% Change	% Change	% Change
Homicide	415	502	500	20.96%	-0.40%	20.48%
Rape	437	478	460	9.38%	-3.77%	5.26%
Robbery	612	668	680	9.15%	1.80%	11.11%
Aggravated Assault	539	498	520	-7.61%	4.42%	-3.53%
Burglary	377	430	408	14.06%	-5.12%	8.22%
Larceny	459	508	571	10.68%	12.40%	24.40%
Motor Vehicle Theft	672	733	707	9.08%	-3.55%	5.21%

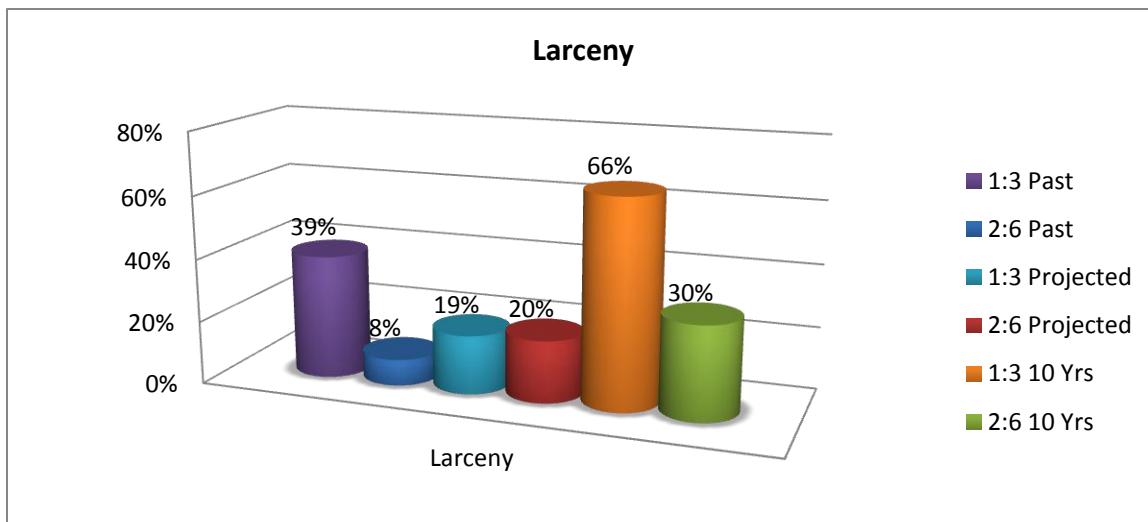
Fresno County Forecasts

Larceny and Homicide crimes showed significant increases in both methodologies when compared to Fresno County. Both crimes are projected to increase but at a slower rate. However, when compared to one another, the data suggests that these crimes are more likely to occur in the 1 to 3 mile radius of the facility, which is not good news.

12% increase in the past 5 years, and a projected increase of 6% in the next five years. If the projections hold true, Homicides will increase by 18% over a ten year period (2010 to 2020).



Larceny had the greatest increase over the last 5 years at 39%. The projected increase over the next 5 years is 20%. Overall, Larceny had the largest increases over a 10 year period at 66%.



Simply stated the exposure to serious violent crime and theft of assets appear to present the greatest crime threats.

Security Report Records Analysis

The following data was collected from the CRMC Security reporting database. When compared to the prior year, campus crimes trended downward. However, Vehicle thefts and Larceny remained relatively static.

CRMC Security	2013	2014	2015	LY vs. YTD % of Change
Rape	0	0	1	NA
Robbery	1	2	1	-50%
Aggravated Assaults	198	199	131	-34%
Burglary	80	80	31	-61%
Larceny	166	107	103	-4%
Motor Vehicle Theft	33	29	30	3%

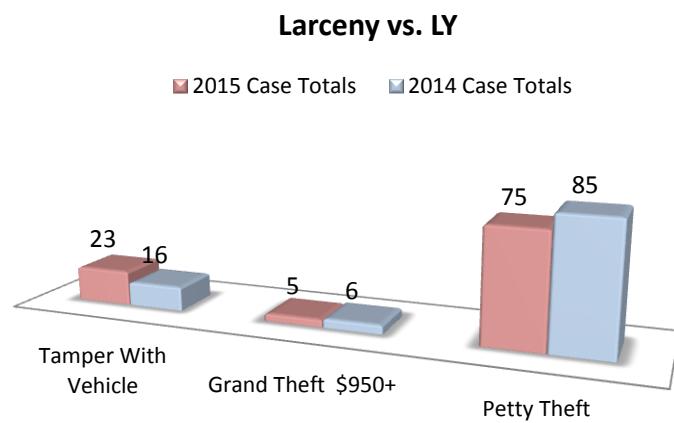
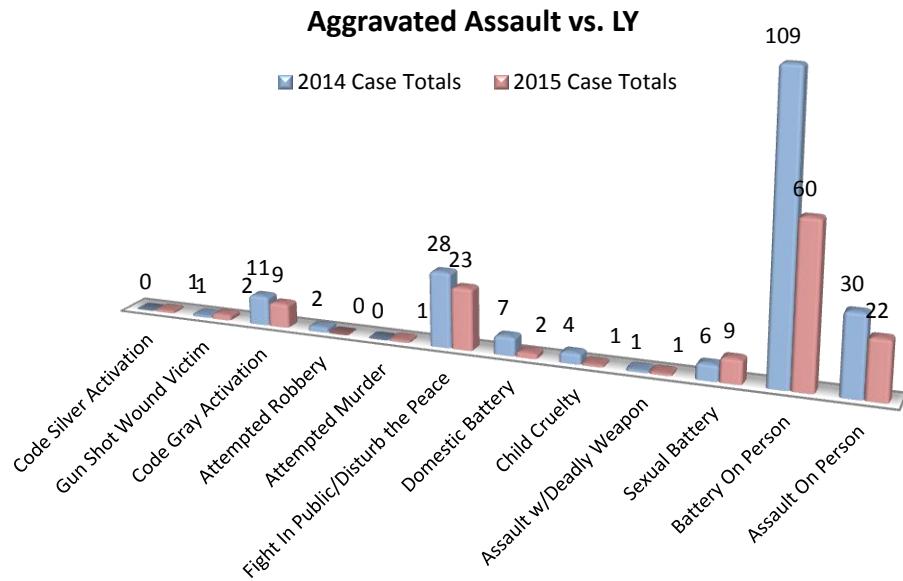
For other security case types, Threats and Weapon Possession increased, vs. LY. Most noteably however, is the consistantly high number of Infant Security (Code Pink) alarms, which averaged more than 200 per year.

CRMC Security	2013	2014	2015	LY vs. YTD % of Change
Elopement	48	23	5	-78%
Infant Security Alarms	193	216	212	-2%
Restraint Applications	2135	1962	1766	-10%
Threats	39	24	31	29%
Trespassing	48	29	27	-7%
Use of Physical Force	223	194	104	-46%
Vandalism	133	84	73	-13%
Vehicle Accidents	224	208	161	-23%
Weapons Possession	17	8	11	38%

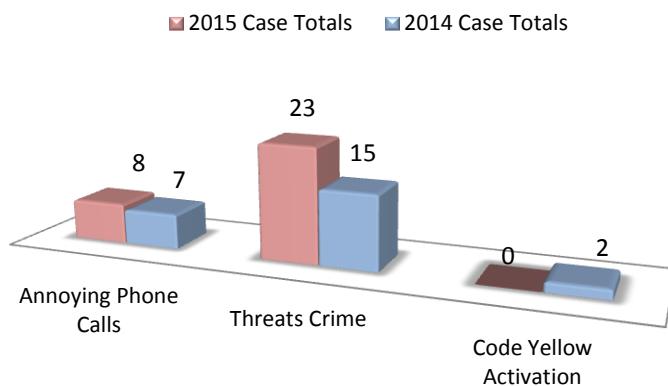
Other minor crimes include, reckless driving and indecent exposer, possession of counterfeit currancy and minor arson offensives. From a safety perspective, slips and falls reports increased by 23%. The Service categories, includes various security duties which necessitate a written report, primarily relating to personal property handling.

CRMC Security	2013	2014	2015	LY vs. YTD % of Change
Other Minor Crimes	9	1	6	500%
Service	3037	2833	2705	-5%
Slip and Falls	64	53	65	23%

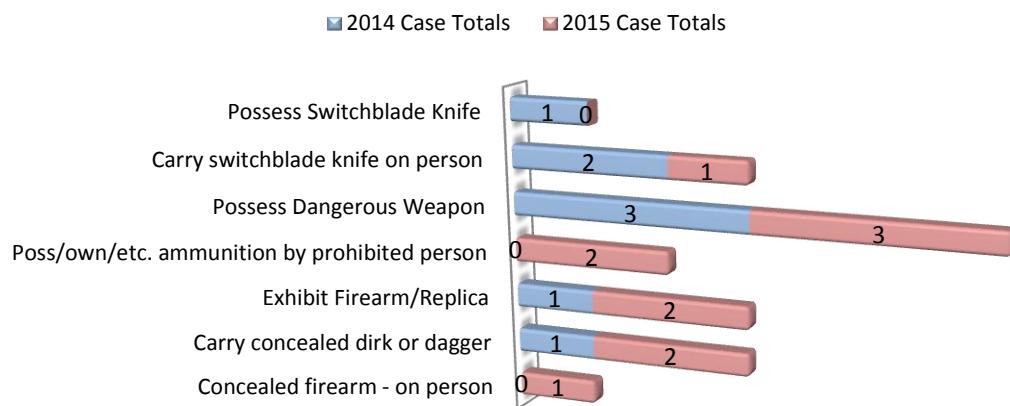
Security Reports Summary



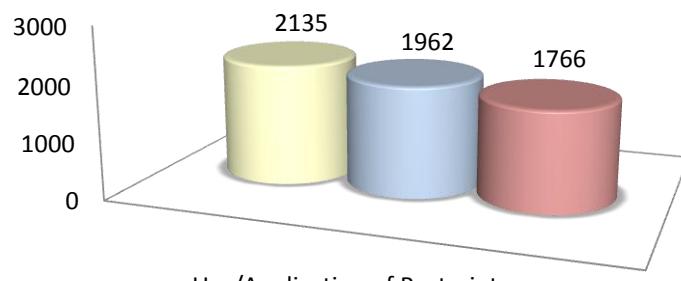
Threats vs. LY



Weapons Possession vs. LY



Clinical Restraint Applications



■ 2013 Case Totals ■ 2014 Case Totals ■ 2015 Case Totals

Site Assessment: Perimeter Access

Moving inward from the surrounding area neighborhoods, onto the campus environment the layers, or zones, of protection gain clarity. This portion of the assessment is to evaluate the risk to the building perimeter through an objective analysis of all external doors in order to better determine vulnerability to external dangers.

Controlling access in this environment from a security perspective requires knowledge of current and future physical and logical access needs, coupled with an understanding of the standards and regulations.

There are 80 potential methods of entry in the hospital. Many of these doors are not regularly used or easily accessible. The specific locations, included in this evaluated are as follows:

- Trauma and Critical Care building
- Annex building
- 1st Floor Bridge Connection
- 1 East
- 10 Story building
- Community Physicians Center, MOB
- 5 Story building
- In-Patient Laboratory

Risk Levels

All external entry points (excluding windows) into the facility were individually assessed and assigned a security risk rating. Each location was evaluated using twenty-seven assessment factors. Each factor was assigned a positive or negative numerical value of 1 or -1. A score of one represented a positive security attribute, while a negative indicated a potential vulnerability. When a risk factor was deemed not applicable the door was assigned "na". Non applicable designations were assigned a value of zero.

Based on the sum of these values a risk rating scale was established with ranged from 16 and -14; the lower the score the greater the security risk.

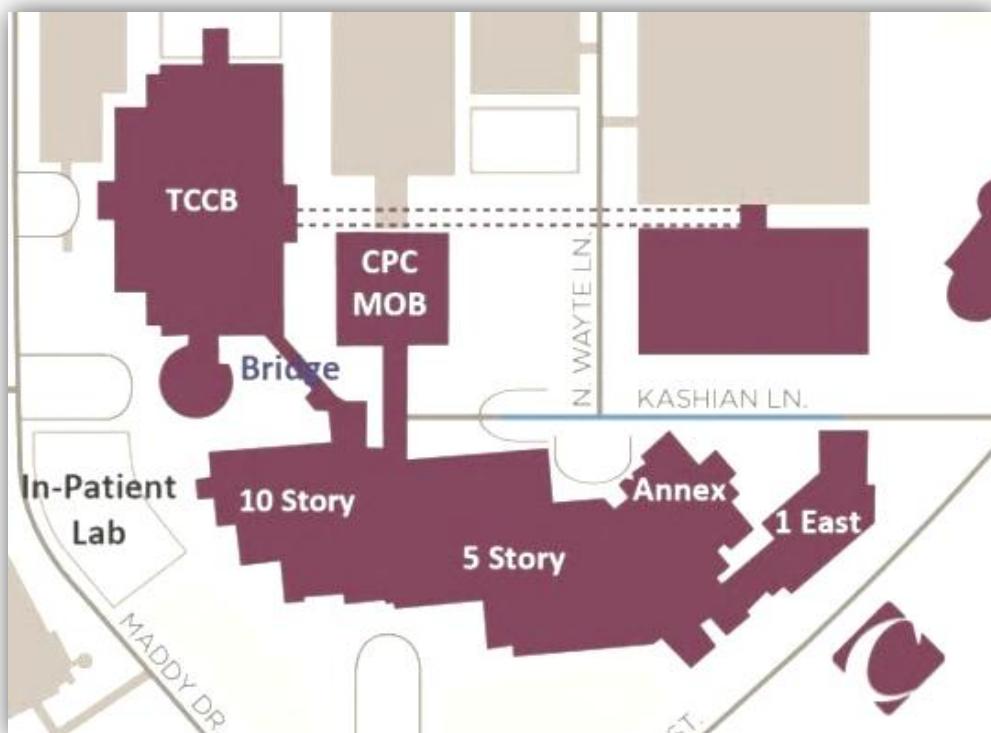
Risk Rating Scale	
Low Risk	16 to 10
Medium Risk	9 to 4
Medium High Risk	3 to -3
High	-4 to -14

List of Risk Factors

- Posted Security Officer
- Adequate Design for Security Purposes
- Access Control Devices
- Door has Handle or Key Core
- Access Controls are appropriate
- Direct CCTV Coverage
- Door is Emergency Egress
- Indirect CCTV Coverage
- Remote location
- Door has Lock
- Door can be easily opened from outside
- Lock has Primus Core
- Frequently accessed after hrs.
- Local Alarm
- New Security Local Alarms
- Door is frequently used
- Burglar Alarm
- After hours coverage
- Limited or No weekend staffing
- CCURE Event
- 24 hr. Visitation
- Adequate Lighting
- Staff habits compromise security
- Correct Level of security feature
- Few staff or alone.
- Probability: High "Y", Low "N"

Risk Analysis by Location

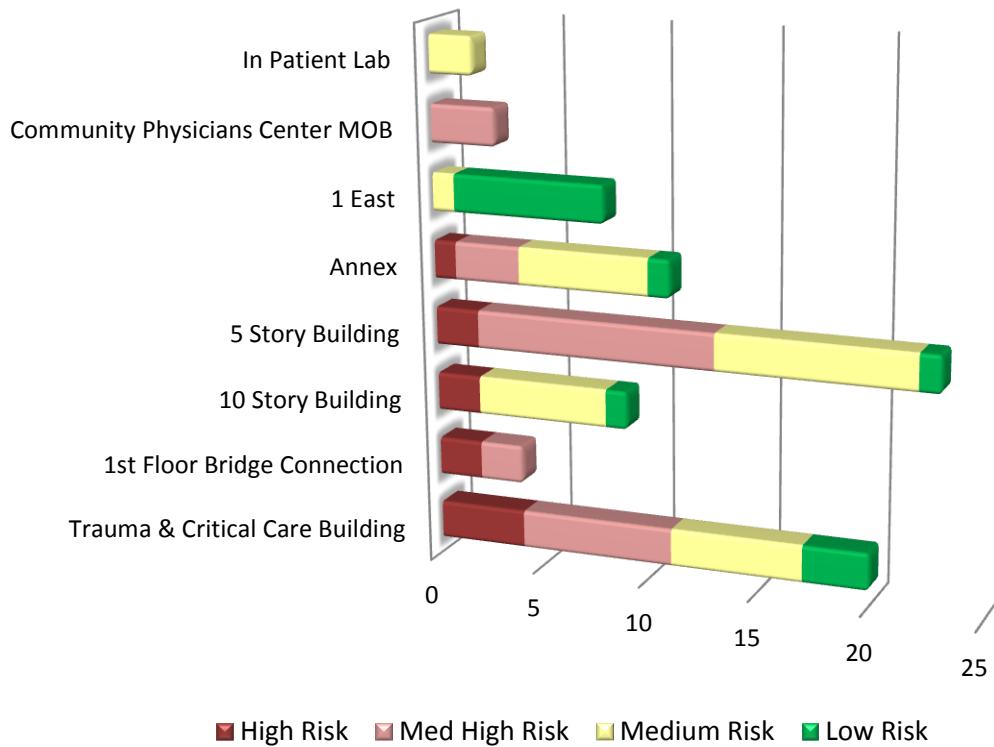
Risk rating for each building is illustrated in this table. The greatest numbers of High Risk doors were found in the Trauma & Critical Care building. The most numbers of Medium High Risk locations were found in the 5 Story building. The 5 Story building was found to have the greatest number of risk locations, overall.



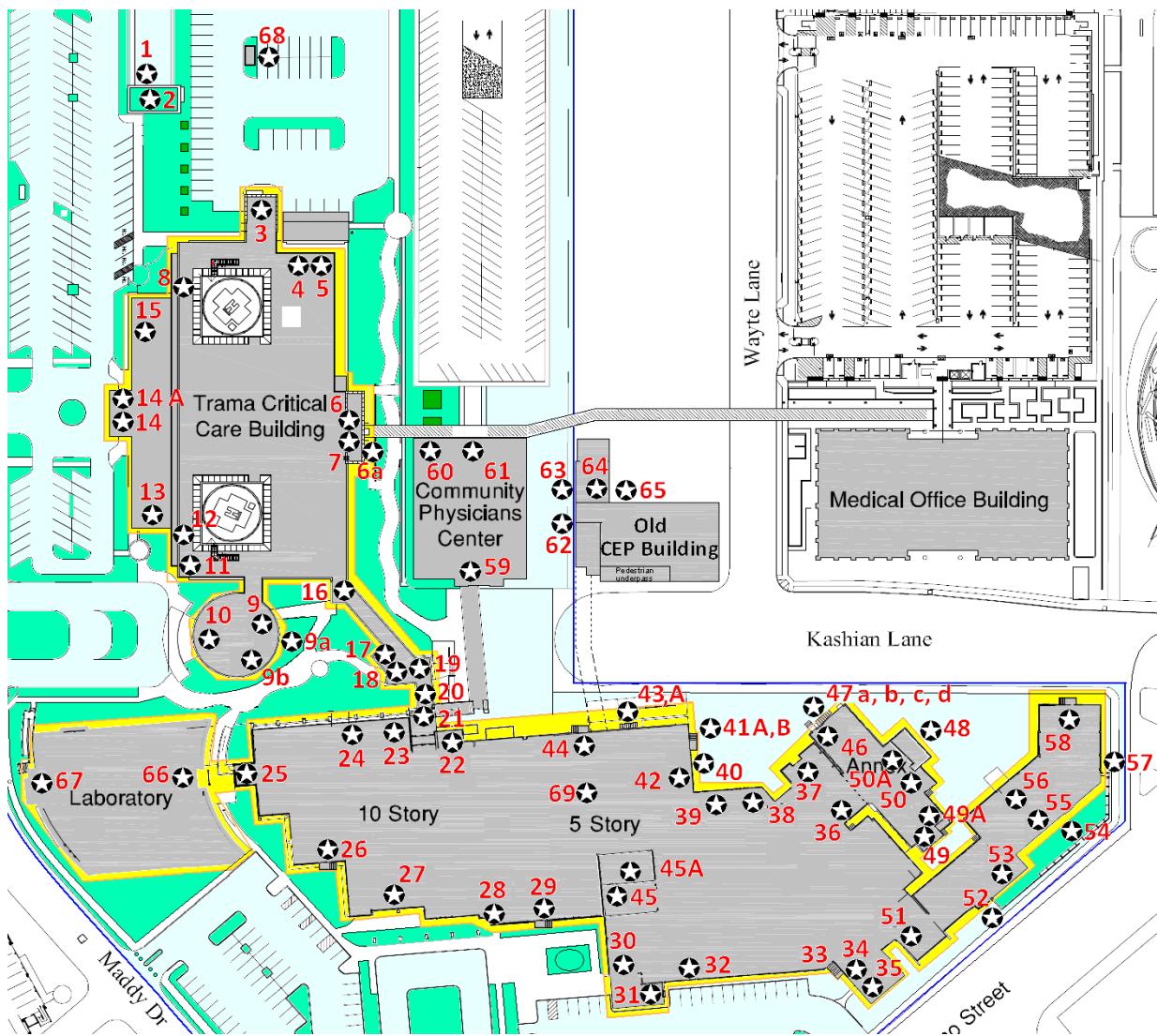
Location Name	High	Med High	Medium	Low	Total
Trauma & Critical Care Building	4	7	6	3	20
1 st Floor Bridge Connection	2	2			4
10 Story Building	2		6	1	9
5 Story Building	2	11	9	1	23
Annex	1	3	6	1	11
1 East			1	7	8
Community Physicians Center MOB		3			3
In Patient Lab			2		2
Totals	11	26	30	13	80



Risk Rating by Building



Perimeter External Entrance Map

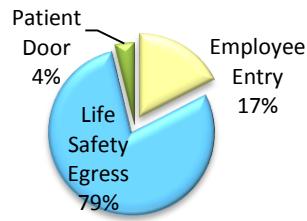


Door Categories

Defining the door is useful to ensure the appropriate technology is applied to ensure it operates in accordance with the need. Patient/public access points are often open but need controls in place to secure in the event of an emergency. Employee entrances need to be secured at all times and should be equipped access control devices to prevent unauthorized entry into the space. Life Safety doors provide emergency egress, not access. Each perimeter entrance door was cataloged into one of three basic categories.

1. Employee Entry
2. Life Safety Egress
3. Patient Door

79% of the doors evaluated in the perimeter assessment fell into the Life Safety category.



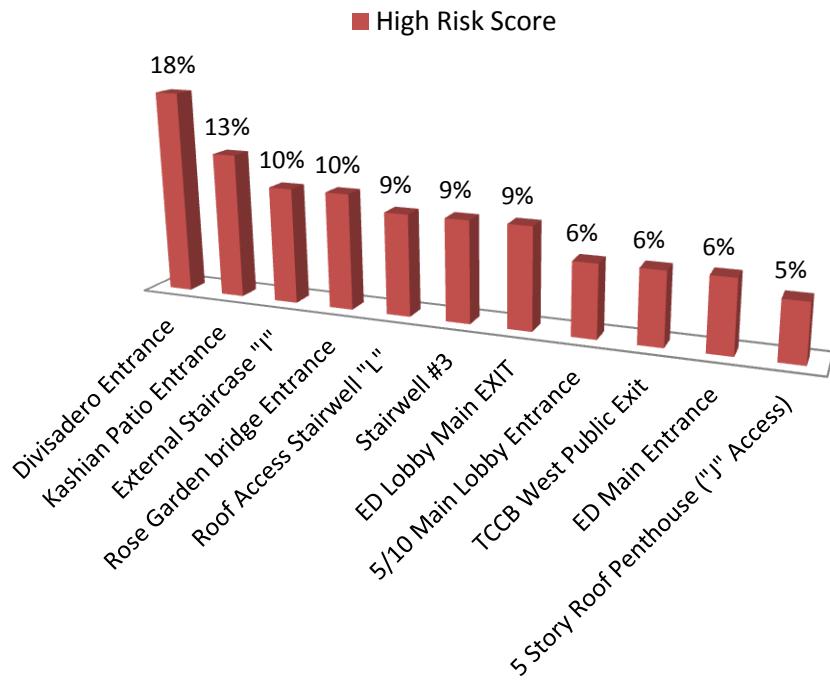
High Risk Locations

There were eleven locations which were identified as High Risk. These locations lacked security features or by virtue of their design were found to be insufficient to effectively control access into the facility.

High Risk Location List

Building	Map #	Door #	Location Name	RISK SCORE
10 STRY	20	H1024C	Divisadero Entrance	-14
Bridge	19	1015B	Kashian Patio Entrance	-10
Bridge	18	1015C	Rose Garden bridge Entrance	-8
5 STRY	43	-	External Staircase "I"	-8
TCCB	9a	1ST3A	Stairwell #3	-7
TCCB	14 A	1508A	ED Lobby Main EXIT	-7
ANNEX	50	A5001B	Roof Access Stairwell "L"	-7
TCCB	11	1521A	TCCB West Public Exit	-5
TCCB	14	1511A	ED Main Entrance	-5
10 STRY	27	-	5/10 Main Lobby Entrance	-4
5 STRY	45 A	-	5 Story Roof Penthouse ("J" Access)	-4

This graph identifies the specific location and its contribution to overall High Risk category total.



High Risk Factors

To better compare and contrast high risk commonalities, assessment factors were grouped into four basic descriptive classifications.

High Risk classifications by contribution to the total risk rating:

- Door Design, Purpose and Location (42%)
- Detection and Deterrent (15%)
- Monitoring (11%)
- Technological Control (32%)

It is important to reiterate that risk levels were determined by assessing safeguards already in place. This table shows assessment factors, with the greatest contribution to each classification.

Top Factors by Classification	
Design, Purpose and Location	
Level of security feature	15%
High Risk Probability	13%
Door is Emergency Egress	13%
Door can be easily opened from outside	13%
Door is easily accessible to Public	13%
<i>Total Contribution</i>	66%
Detection & Determent	
Few staff or alone in area	40%
No Posted Security Officer	32%
No Direct CCTV Coverage	20%
<i>Total Contribution</i>	92%
Monitoring	
Location is subject to 24 hr. Visitation	44%
Limited After hours coverage	39%
Limited or No weekend staffing	17%
<i>Total Contribution</i>	100%
Technological Control	
No Access Control Devices	20%
No CCURE Event	18%
NO Local Alarm	18%
Door is frequently used	13%
<i>Total Contribution</i>	69%

Medium High Risk Locations

There were twenty-six locations which were identified as Medium High Risk.

Medium High Risk Locations

Building	Map #	Door #	Location Name	RISK SCORE
5 STRY	38	V1326C	Pulmonary Function Waiting Room Exit	-3
5 STRY	35	V1500	Endo Emergency Exit #2	-2
5 STRY	39	V1037	Old Short Stay Entrance	-2
5 STRY	45	-	5 Story Roof Stairwell "J" Access	-2
TCCB	9	1009A	Rotunda Rose Garden exit	-1
Bridge	16	1015A	TCCB Rose Garden Emergency Exit	-1
ANNEX	48	A1001A	East Staff Entrance	-1
TCCB	2	CH0011	Loading dock door	0
TCCB	10	1014A	Rotunda Main Entrance	0
Bridge	17	T1ST4	Stairwell #4	0
5 STRY	33 A	-	Cyberknife S. External Emergency Exit	0
5 STRY	41 A	V2220B	Stair "H" 2nd Floor OR Emergency Exit	0
5 STRY	69	V3205	3 Central Roof Access	0
ANNEX	50A	-	Roof Mechanical space door.	0
5 STRY	34	V1370B	Endo Emergency Exit #1	1
CPC	61	-	CPC 2nd Floor N. Bridge Entrance	1
5 STRY	37	V1331A	Neurodiagnostics Emergency Exit	2
CPC	60	-	CPC Lobby Entrances	2
TCCB	68	KIST-1A	Lot 8 Basement Entrance Door	3
TCCB	4	1106A	EMS Ambulance Bay	3
TCCB	7	2003	2nd Floor bridge access door	3
TCCB	9b	1009C	Rotunda Smoke ventilation Windows	3
5 STRY	36	V1342	Stairwell "F"	3
5 STRY	41	-	External Staircase "H"	3
ANNEX	47	-	Annex N. External Stair "E"	3
CPC	59	-	CPC 2nd Floor S. Entrance	3

Medium High Risk Factors

This table identifies the specific location and their contribution to the Medium High Risk rating in percent to the total number of locations in this risk rating.

4%	8%	12%	27%	31%
Pulmonary Function Waiting Room Exit	CPC 2nd Floor N. Bridge Entrance	5 Story Roof Stairwell "J" Access	3 Central Roof Access	2nd Floor bridge access door
	CPC Lobby Entrances	East Staff Entrance	Cyberknife S. External Emergency Exit	Annex N. External Stair "E"
	Endo Emergency Exit #1	Endo Emergency Exit #2	Loading dock door	CPC 2nd Floor S. Entrance
	Neurodiagnostics Emergency Exit	Old Short Stay Entrance	Roof Mechanical space door.	EMS Ambulance Bay
		Rotunda Rose Garden exit	Rotunda Main Entrance	External Staircase "H"
		TCCB Rose Garden Emergency Exit	Stair "H" 2nd Floor OR Emergency Exit	Lot 8 Basement Entrance Door
			Stairwell #4	Rotunda Smoke ventilation Windows
				Stairwell "F"

These classifications made up the Medium High Risk rating, listed in percent to total.

- Door Design, Purpose and Location (28%)
- Detection and Deterrent (23%)
- Monitoring (15%)
- Technological Control (34%)

This table shows assessment factors with the greatest contribution to each classification.

Top Factors by Classification	
Design, Purpose and Location	
Door is Emergency Egress	25%
In a Remote location	24%
Level of security feature	19%
<i>Total Contribution</i>	67%
Detection & Deterrent	
No Posted Security Officer	35%
Few staff or alone	30%
No Direct CCTV Coverage	20%
<i>Total Contribution</i>	86%
Monitoring	
Limited After hours coverage	47%
Limited or No weekend staffing	42%
<i>Total Contribution</i>	89%
Technological Control	
No Local Alarm	23%
No CCURE Event	22%
Door has Handle or Key Core	19%
<i>Total Contribution</i>	64%

Medium Risk Locations

There were thirty locations identified as Medium Risk.

Medium Risk Locations

Building	Map #	Door #	Location Name	RISK SCORE
TCCB	6a	1003B	Fire Control Room	4
10 STRY	24	-	Sequoia E. Conf Room Emergency Exit	4
5 STRY	40	V1034B	Medical Affairs Satellite Office	4
5 STRY	42	V2255B	PACU Emergency Exit, 2nd Floor	4
TCCB	1	S0001A	Loading dock Man door	5
10 STRY	25	HOSTA-B	Stairwell "A"	5
5 STRY	29	5S0/12	Basement S. Emergency Exit	5
5 STRY	30	V1063B	Doctors Lounge entrance	5
5 STRY	31	V1069B	Stairwell "K"	5
5 STRY	33	V00224	Cyberknife Internal S. Emergency Exit	5
5 STRY	43 A	V3226A	Stair "I" 3rd floor OR Emergency Exit	5
ANNEX	49	A1003A	Annex 1 LA S. Emergency Exit, "D"	5
10 STRY	28	HISTB-B	Stairwell "B"	6
5 STRY	41 B	V3221B	Stair "H" 3rd Floor OR emergency exit	6
5 STRY	44	V0091	Basement Smoking Exit	6
1 EAST	57	-	1E, Patio east gate.	6
10 STRY	22	HISTC-C	Stairwell "C"	7
ANNEX	47 a	A2002E	Annex 2 LA N. Emergency Exit, Stair "E"	7
ANNEX	47 b	A3002F	Annex 3 LA Fire Escape Exit, Stair "E"	7
ANNEX	47 c	A4014C	Annex 4 LA Fire Escape Exit Stair "E"	7
ANNEX	47 d	A5021	Annex 5 LA Fire Escape Exit Stair "E"	7
ANNEX	49A	A2010B	Annex 2 LA S. Emergency Exit Stair "D"	7
LAB	67	-	Maddy Lab West Emergency Exit	7
TCCB	12	1519B	TCCB S.W. door	8
10 STRY	23	-	Outtakes Café Rose Garden entrance	8
TCCB	3	1ST1A	Stairwell #1	9
TCCB	5	1102A	East Hall staff door	9
TCCB	6	1ST2	Stairwell #2	9
10 STRY	26	10S0-19	Basement SW Emergency Exit	9
LAB	66	-	Maddy Lab Main Entrance	9

Medium Risk Factors

Classifications by contribution to the total risk rating:

- Door Design, Purpose and Location (22%)
- Detection and Deterrent (27%)
- Monitoring (18%)
- Technological Control (33%)

This table shows assessment factors with the greatest contribution to each classification.

Top Factors by Classification

Design, Purpose and Location	
Door is Emergency Egress	43%
In a Remote location	38%
<i>Total Contribution</i>	80%

Detection & Determent	
No Posted Security Officer	39%
Few staff or alone	30%
No Direct CCTV Coverage	21%
<i>Total Contribution</i>	91%

Monitoring	
Limited or No weekend staffing	48%
Limited After hours coverage	48%
<i>Total Contribution</i>	96%

Technological Control	
Door has Handle or Key Core	30%
No Access Control Devices	23%
No CCURE Event	17%
<i>Total Contribution</i>	70%

Low Risk Locations

There were thirteen locations identified as Low Risk.

Low Risk Locations

Building	Map #	Door #	Location Name	RISK SCORE
5 STRY	32	-	Dialysis Emergency Exit	10
ANNEX	46	A1018B	NAPS Staff Lounge Emergency Exit	10
1 EAST	53	V1461	1E Supply Room	10
10 STRY	21	H10S2-11	2nd Floor CPC bridge entrance	11
1 EAST	56	V1419	1E Main Entry Door	11
TCCB	13	1516A	TCCB ED Area 2 Emergency Exit	12
1 EAST	52	-	1E Patio external S. Access Door	12
TCCB	8	1146	ED NW Emergency Exit	14
TCCB	15	1507D	TCCB 1 ED North Wait Emergency Exit	14
1 EAST	54	-	1E Patio external central door.	14
1 EAST	51	V1401B	1E South Exit Door	15
1 EAST	58	V1420D	1E, east Exit Door	15
1 EAST	55	V1416B	1E Patio Door	16

Classifications by contribution to the total risk rating:

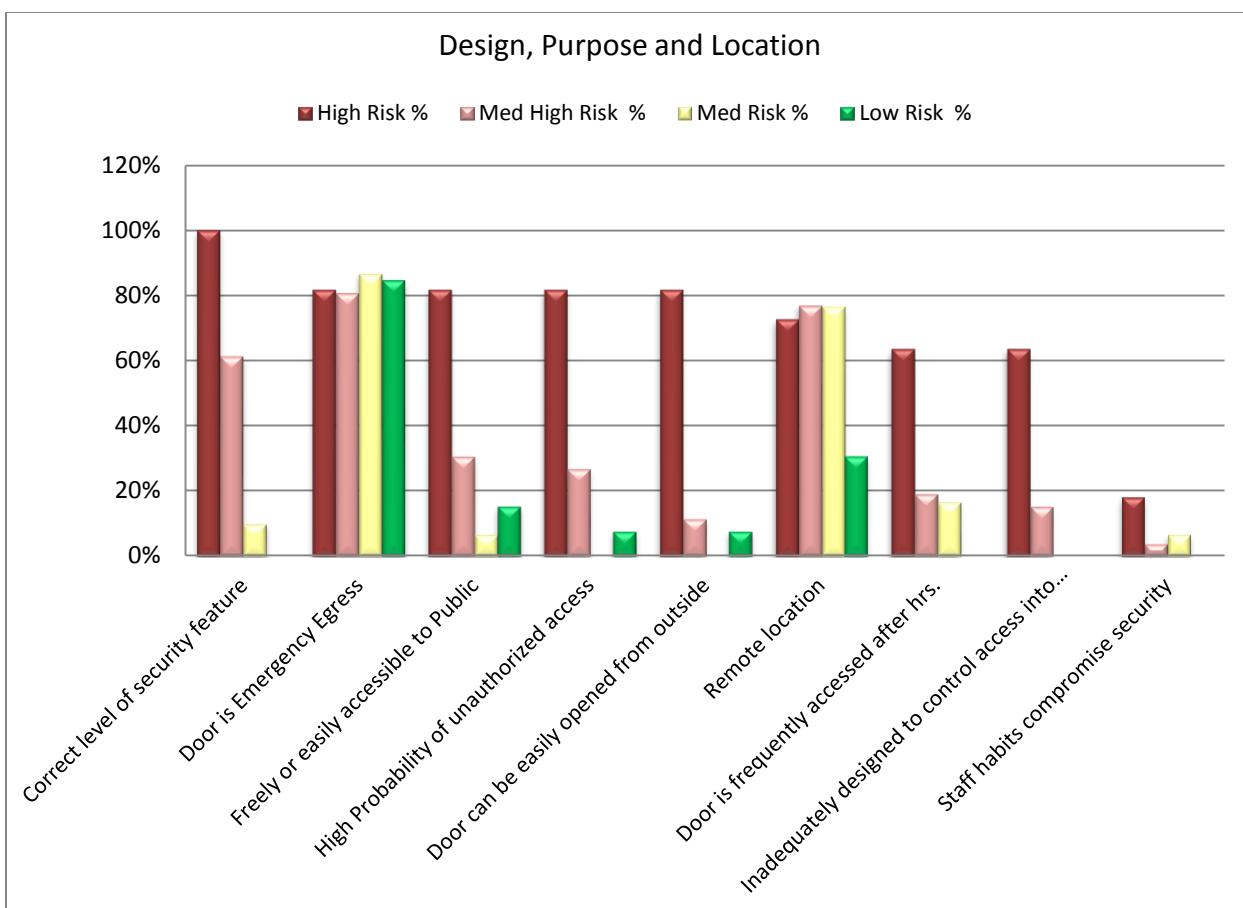
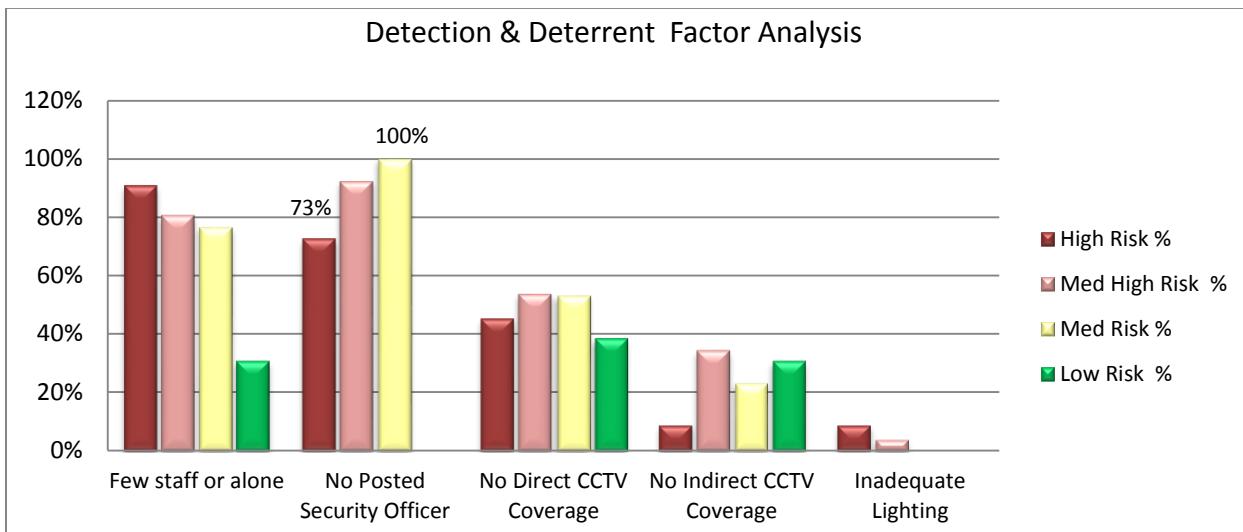
- Door Design, Purpose and Location (28%)
- Detection and Deterrent (19%)
- Monitoring (16%)
- Technological Control (37%)

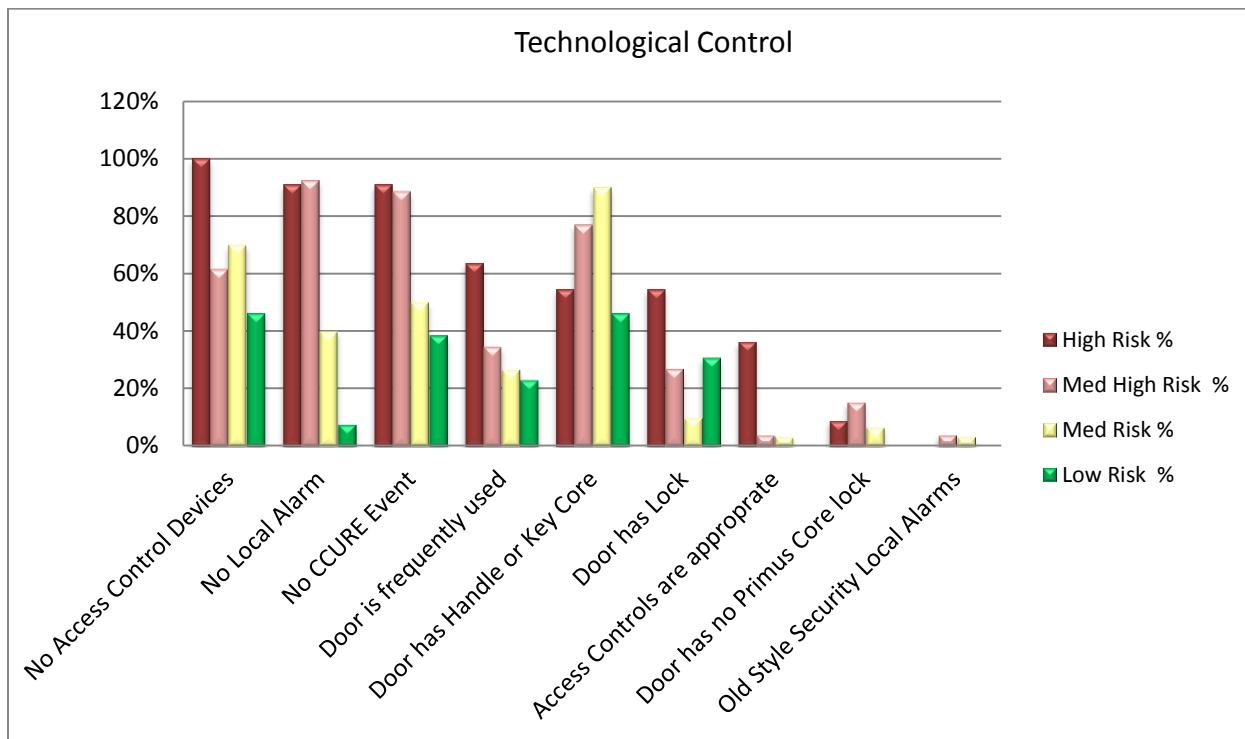
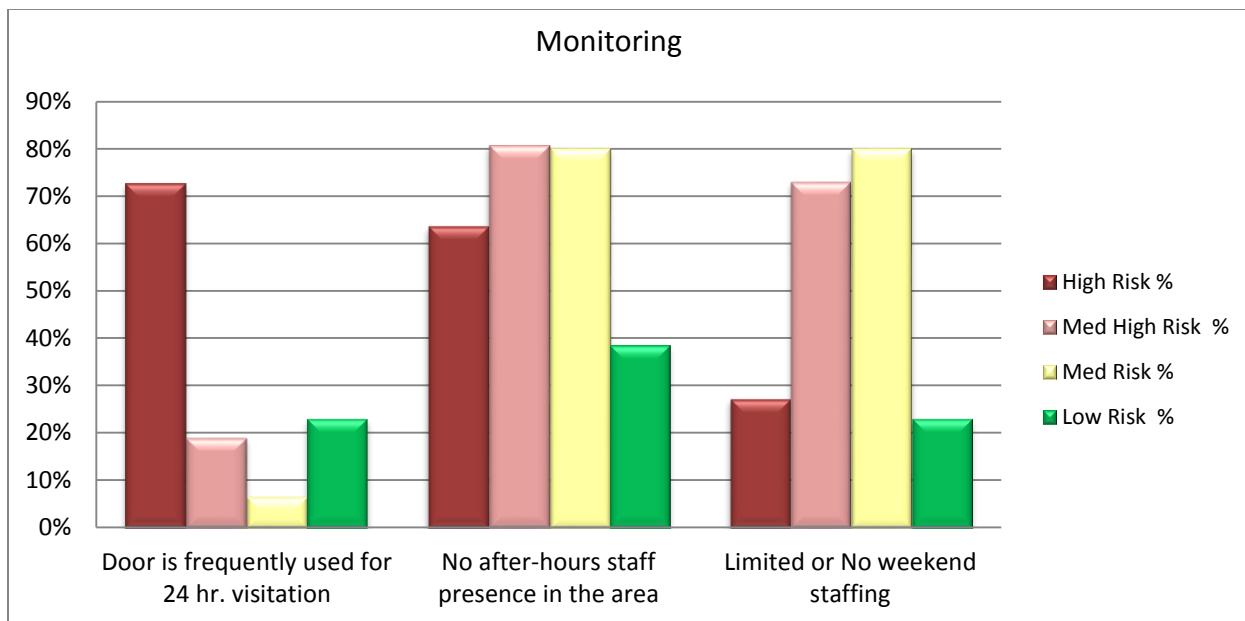
Assessment factors with the greatest contribution to each classification.

Top Factors by Classification	
Design, Purpose and Location	
Door is Emergency Egress	58%
Remote location	21%
Freely or easily accessible to Public	11%
<i>Total Contribution</i>	89%
Detection & Deterrent	
Direct CCTV Coverage	38%
Indirect CCTV Coverage	31%
Few staff or alone.	31%
<i>Total Contribution</i>	100%
Monitoring	
After hours coverage	45%
Limited or No weekend staffing	27%
24 hr. Visitation	27%
<i>Total Contribution</i>	100%
Technological Control	
Access Control Devices	24%
Door has Handle or Key Core	24%
CCURE Event	20%
<i>Total Contribution</i>	68%

Risk Factor Comparative Analysis

These graphs are a side by side comparison of assessment factors and how they contributed to each risk rating. This data is useful in understanding how assessment factors contributed to each risk rating. For example, all medium risk locations had no a posted security officer, while only 73% of high risk had no security officer.

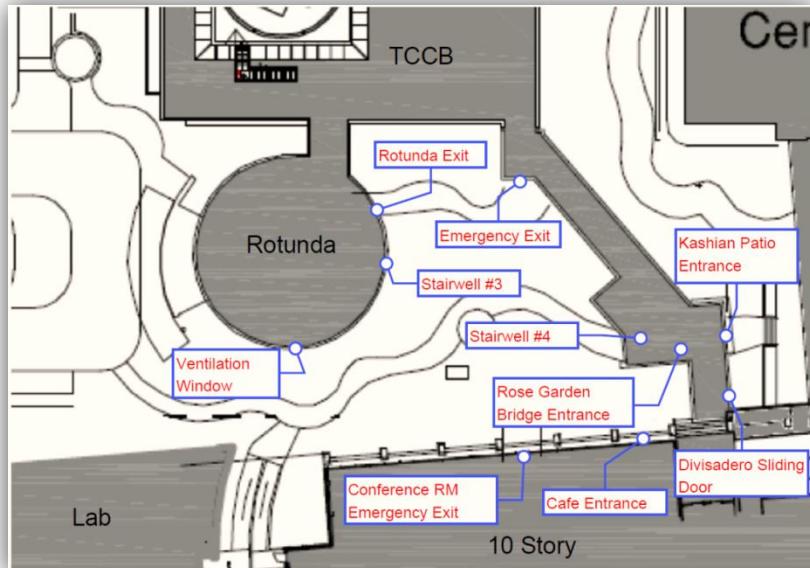




Site Assessment: Controlling Access

One commonality between all High Risk locations is the inability to effectively control access into the space. While an individual door may be outfitted with specific security safeguards to address a given vulnerability, this may not address the root cause. Understanding the relationships between locations is important to the development of a comprehensive and effective security protection strategy.

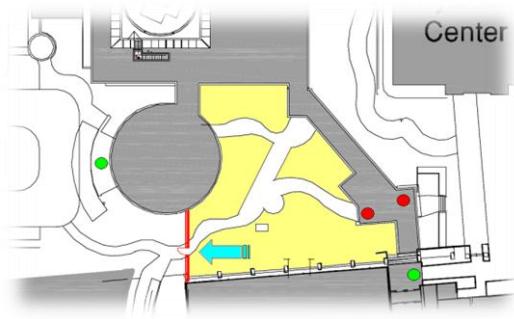
The Rose Garden patio contains eight possible access points into the facility. Controlling access into this space is essential to help restrict and channel access to and away from the buildings perimeter.



1. *Kashian Patio Entrance (High Risk)*
2. *Divisadero Sliding Entrance (High Risk)*
3. *Rose Garden Bridge Entrance (High Risk)*
4. *Stairwell #3 (High Risk)*
5. *Smoke Ventilation Windows (Medium High)*
6. *Rotunda Rose Garden exit (Medium High)*
7. *Rose Garden Emergency Exit (Medium High)*
8. *Stairwell #4 (Medium High)*
9. *Outtakes Café entrance (Medium Risk)*
10. *Sequoia E. Conference Room Emergency Exit (Medium, Risk)*

Rose Garden Protection

Having the capacity to restrict access into the Rose Garden adds an additional layer of protection at the perimeter. A decorative fence and security gate could be installed as a safeguard intended to deter, deny access to and slow down possible malefactors. The gate could be equipped with access control devices and automated programming which secure the gate at designed times or remotely engages during emergency situations.



Bridge Passageway

The 1st floor bridge connection passageway is an area accessible to the public at all times. The physical design of this space and public accessibility do not readily support visitor reception or screening processes during or after normal business hours. Patients and visitors entering this location from the west side Rose Garden entrance or two east side Kashian patio entrances, are not funneled directly to staffed reception areas. Instead, persons heading south arrive to the Main Lobby, and those heading north arrive to the Rotunda Main Lobby.

The TCCB Rotunda main entrance is staffed by security staff at all time. However, the security desk is located at the near the entrance. Those arriving from the bridge passageway bypass the security desk and often proceed onto the public elevators, without detection.

The 10 Story Main Lobby reception desk is staffed by a Customer Service Ambassadors until 2:30pm, after which security staff takes over. Their presence serves primarily as a psychological deterrent to wrongdoers, but beyond their presence and observations skills no other screenings takes place. After visiting hours, Security relocates to a position near the Main Entrance. From here, security officers monitor the unlocked entrance and screen visitors granted after hour visitation privileges. Because the bridge connection passageway is centrally located between the Rotunda and 10 Story Main entrance, security cannot effectively control access in and out of this area.

Restricting ingress after hours can be achieved by simply locking doors into the area. Although, at least two of the three entrances are designated for emergency egress and therefore must remain unlocked from the inside. As a result, these doors are vulnerable to someone from the inside holding the door open for another on the outside. Additionally, both east entrances are frequently used by smokers, heading to the designated smoking patio area.

Recommendations:

- Restrict ingress into the bridge passageway after hours.
- Designate the automatic sliding entrance as the primary after hour's entrance this area.
- Install access control devices capable of remote release, video surveillance and two-way communications system on the automatic sliding door.
- Security should control all access from the automatic sliding door.

TCCB South East Corridor

Continuing north down the bridge passageway, one approaches the staff only entrance into the Emergency Department. Patients and visitors must make an abrupt left turn, to proceed into the Rotunda or nearby exit. The problem with this circulation design is one of perception. When the double doors open, the entire east corridor becomes visible.

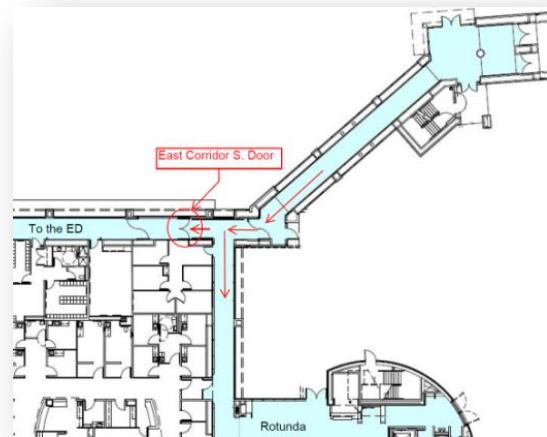
Those unfamiliar with the facility are left with a brightly lit and inviting path. Once past these doors, one is afforded unrestricted access into the ED and nearby stairwell. This circumstance has been corrected with the removal of the automatic door opener mechanism. Staff must still use an access badge to enter, but now the doors must be opened manually. Unfortunately this circulation design can be found on five floors of the TCCB.

In 2015, the doors in the photograph were replaced with a new style. The original versions were equipped with an internal latching mechanism which engaged fixed pins that were affixed to the door frame. This design concealed the latches and prevented manipulation.

The new doors utilize a different design which has proven to be less affective. These doors utilized a mechanical astragal installed on the leading edge where the two doors meet upon closing. The mechanical astragals must be aligned correctly in order for the doors to secure properly. However, because the astragals are on the leading edge, they are prone to impacts by gurneys, beds, carts and staff. When the astragals fall out of alignment, the doors do not secure properly. The fix is a very simple adjustment; however, because these door use automated openers, staff are generally unaware of the misalignment and do not report the issue to maintenance.

Recommendations:

- Consider a redesign for the north end bridge passageway to direct persons away from staff only areas.
- Replace the current double doors with ones less prone to mechanical failure.
- Update way-finding signage to more effectively channel persons away from staff only areas.



After Hours Entrance

After-hours is a primary concern and time of risk for CRMC. At this time, Security personnel are posted at each of the three primary entrances into the facility after-hours.

- Emergency Department Public Entrance
- 10 Story Main Entrance
- TCCB Rotunda Main Entrance

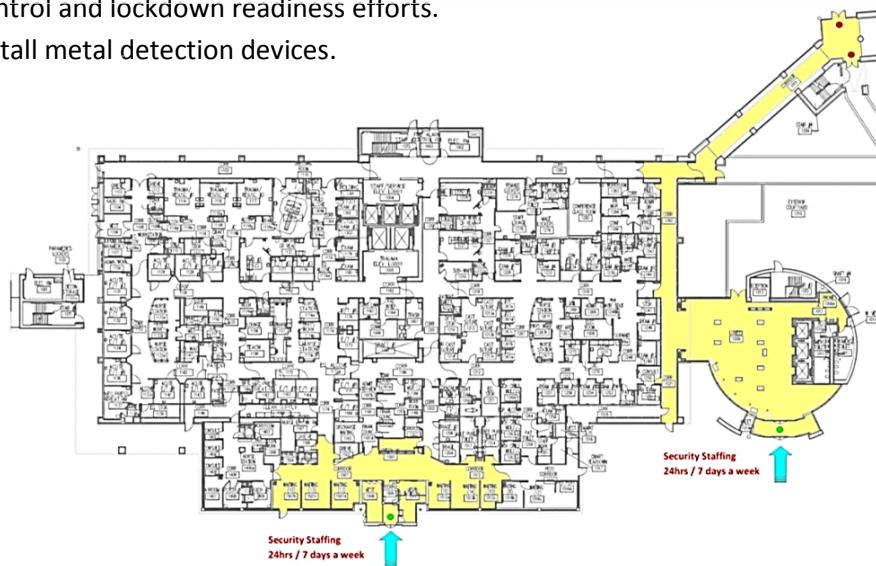
There are a number of advantages to using a single access point into the facility after hours.

Managing multiple entrances creates multiple points of failure. In emergency situations or times of heightened security, access can more readily be controlled from a single point of entry. Visitor and patient throughput, customer service and weapon screening can all be better managed from one centralized location.

Way-finding systems, signage and lighting enhancements can be more effectively disseminated to channel visitors and patients to a specific entrance located at the Rotunda. Door access controls, supplemented by video surveillance camera equipped with an audio and remote release capability could be deployed to allow security personnel positioned away from the entrance, to authorize and grant access as required. Authorized personnel can utilize their employee access badge to enter controlled spaces.

Recommendations:

- Reduce the number of non-emergency after-hours public entrances from two to one.
- Designate the TCCB Rotunda entrance as the primary non-emergency after hour's public entrance.
- Equip unsupervised entrances with access controls, audio/video monitoring and remote release locking systems.
- Redesign the Rotunda entrance to effectively screen visitors/patients and support access control and lockdown readiness efforts.
- Install metal detection devices.



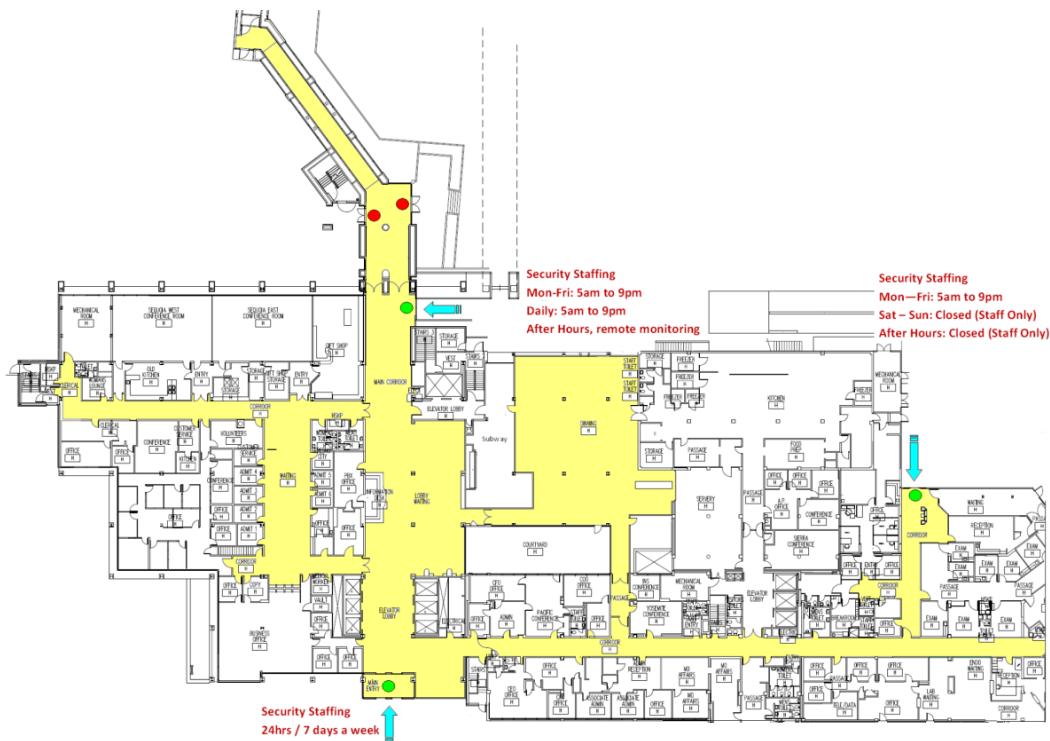
Main Entrances:

CRMC is faced with a unique security /safety challenge due to the high volume of visitors and patients, fast paced environment and round the clock services. The design features and physical characteristics of the facility impact how people move about the facility. To better control access into the facility, and support emergency readiness, it is time to consider a redesign of all main entrances.

The emergency department public entrance is a highly volatile location with sliding doors leading into this space. However, due to the high volume of use, these doors are prone to mechanical failure.

- Redesign of the Main Entrance to support visitor management and access control.
- Visitor Management system, designed to automate the process of registering a visitor, printing a badge and capturing detailed information by electronically scanning a form of identification.

The Old Short Stay entrance is equipped with CCTV monitoring and access control devices. Programmed security system events engage and restrict public accessibility after hours. However, during daytime operations, access to this entrance is not monitored or controlled.



Lockdown Readiness

Having the ability to quickly and efficiently restrict access, to “Lockdown” a corridor, department or the entire hospital is an important indicator of emergency preparedness. Although, of equal importance, is how fast the facility, can be locked down.

The ability to restrict access quickly is at the heart of any access control system. And when managed from a central location, a facility lockdown can be fast and effective. While the current access control system supports this functionality, its potential has never been fully realized. Therefore, it is recommended that lockdown system functionality be exploited and incorporated into current and future security access control strategies.

Protecting Entrances:

The locations listed below are subject to heavy vehicular and pedestrian traffic.

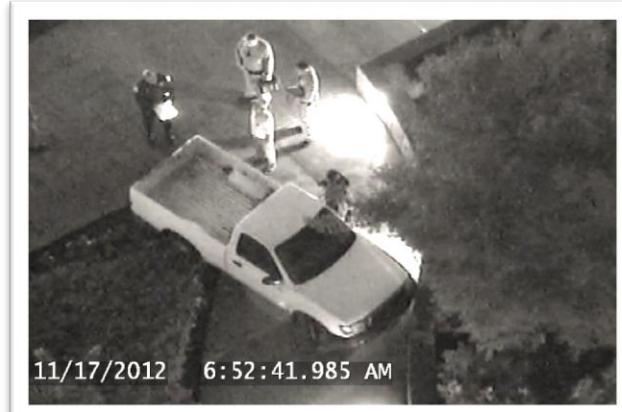
- ED Main Entrance
- EMS Ambulance Entrance
- TCCB Rotunda Main Entrance
- 5/10 Story Main Entrance



The absence of physical protective barriers such as a bollard, in these areas leaves them vulnerable to intended or unintended, ramming of a vehicle into the building. At the 10 Story Main Entrance, bollards exits. However, the distance between bollards may be insufficient to prevent a vehicle from ramming the building.

It is recommended to install bollards to prevent the intended, or unintended, ramming of vehicle into a building or entrances. A high emphasis should be placed on locations with glassed door entries off driveways, such as the Ambulance entrance and the ED Public entrance. These locations are often highly congested and chaotic at times. Bollards could also be used, alongside temporary security barricades or with caution tape to separate flow and direct traffic to or away from specific areas.

In November 2012, a person driving under the influence of alcohol drove a pickup truck into the Rose Garden. The installation of bollards should also be considered for this location.



Loading Dock:

The TCCB Loading dock is vulnerable to theft, unauthorized access and terrorism. The primary problem is the loading dock's overhead door, which is open during business hours. Additionally the shipping and receiving staff is limited in numbers and the area is often left unattended.

Recommendations:

- Install a restrictive barrier that prevents unimpeded access into the loading dock.
- Consider safeguards such as fencing, cargo doors or other means to secure the external loading dock door from the surrounding street.



Workplace Violence

The Fresno Bee

CRIME MARCH 23, 2015

Two dead in murder/suicide at pediatrics office in downtown Fresno

HIGHLIGHTS
A man and woman are dead after a shooting at a downtown Fresno pediatrics medical office.



By Jim Guy - The Fresno Bee
Fresno police say a man with a handgun felled five children before turning his gun on himself Tuesday.

NBC NEWS

US WORLD LOCAL POLITICS HEALTH TECH SCIENCE POP CULTURE BUSINESS INVESTIGATIONS SPORTS

NOV 4 2015, 7:18 PM ET

Four Wounded, Attacker Dead After Stabbing Spree at UC Merced: Officials



By Associated Press - Tuesday, November 17, 2015
A California college student wielding a knife on Wednesday shot dead by police, authorities said.

The Washington Times



Former Fresno State football player charged in campus threat

By - Associated Press - Tuesday, November 17, 2015
FRESNO, Calif. (AP) - A football player has been charged with threatening to shoot described a plan to shoot connection to the Nov. 2

Los Angeles Times

DEC. 2, 2015

Deadliest U.S. mass shootings | 1984-2015

By LOS ANGELES TIMES STAFF

DECEMBER 2, 2015 12:39 P.M.

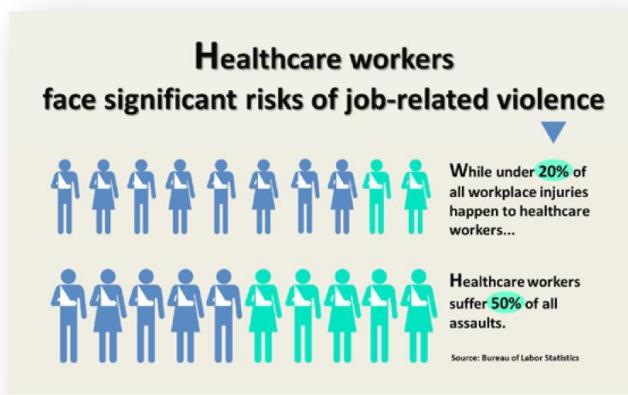
DEVELOPING: 14 dead, 21 wounded | San Bernardino, Calif.



Law enforcement officials confirmed that 14 people are dead and 21 wounded in a shooting at the Inland Regional Center in San Bernardino.

Violence in the Workplace

Many healthcare workers face threats and physical violence on the job while caring for patients. According to the Bureau of Labor Statistics, from 2002 to 2013, incidents of serious workplace violence were four times more common in healthcare than in private industry on average. Additionally, healthcare accounts for nearly as many serious violent injuries as all other industries combined.



In a recent report published by the Occupational Safety and Health Administration (OSHA) titled Guidelines for Preventing Workplace Violence for Healthcare Workers, they site several healthcare related risk factors relating to violence:

Patient and Healthcare Setting-Related Risk Factors

- Working directly with people who have a history of violence, substance abuse and gang affiliations
- Poor environmental design
- Prevalence of firearms, knives and other weapons among patients and visitors
- Working in neighborhoods with high crime rates

Organizational Risk Factors

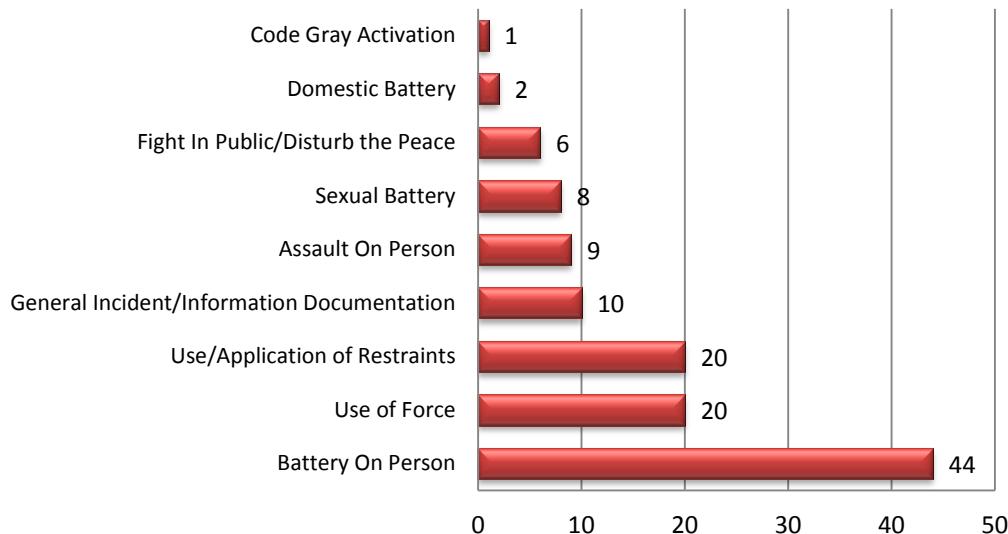
- Lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors
- Working when understaffed
- High worker turnover
- Inadequate security and mental health personnel on site
- Long waits for patients and overcrowded, uncomfortable waiting rooms
- Unrestricted movement of the public in clinics and hospitals
- Perception that violence is tolerated and victims will not be able to report the incident to police and/or press charges

Assault by Security Report Type

The following data was collected from CRMC Security reports, relating to assaults and battery for 2015.

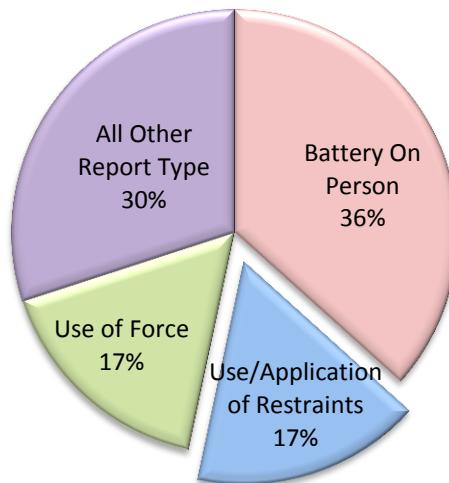
- ❖ The types of security assault related reports varied by circumstance.

Assault by Security Report Type



- ❖ 70% of assault related reports were found these three report types:

1. Battery on person
2. Application of restraints
3. Use of Force



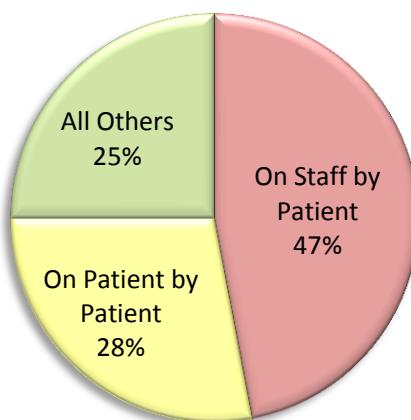
Who's at Risk

In early 2015, specific assault related fields were added to the Security reporting database. Prior to these additions, there was no meaningful way to discern, which demographic groups were most impacted by violent encounters.

This table is an analysis of assault/battery reports generated by security in 2015.

Assault/Battery	Battery	Assault	Total	% to Total
On Staff by Patient	17	39	56	47%
On Patient by Patient	21	13	34	28%
On Patient by Staff	2	5	7	6%
On Visitor by Visitor	4	2	6	5%
On Staff by Intruder	1	3	4	3%
On Staff by Visitor	0	4	4	3%
On Patient by Visitor	2	1	3	3%
On Visitor by Patient	1	2	3	3%
On Patient by Intruder	0	1	1	1%
On Staff by Staff	1	0	1	1%
On Visitor by Intruder	0	1	1	1%
	49	71	120	

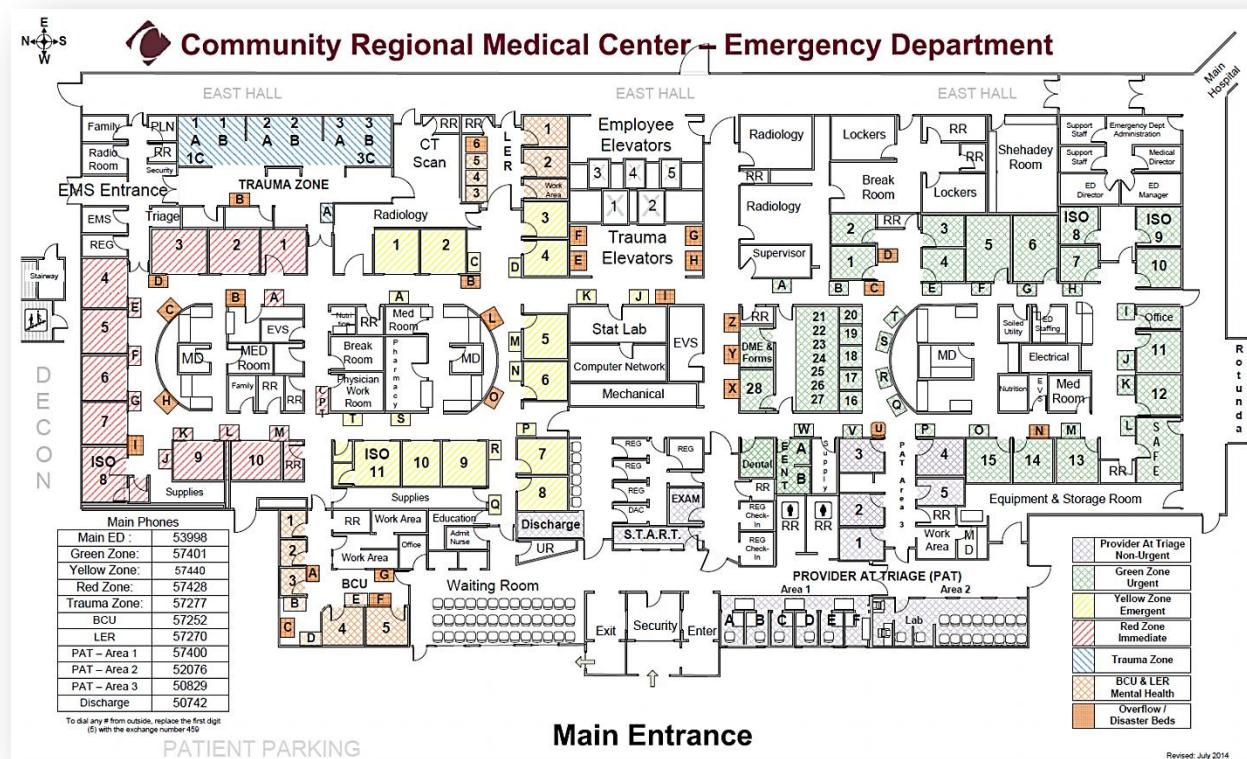
The data reveals the most prevalent violence being experienced by hospital staff is generated by the same people who are being cared for—patients.



Where Assault Occur

The CRMC emergency department has the greatest propensity for disruptive behaviors. Extreme mental and physical factors, acute psychiatric manifestations, drug and alcohol abuse by patients and visitors, the mix of patients and service providers outside the medical staff (police, fire, ambulance, etc.), and often chaotic circumstances combine to produce a very high-risk environment.

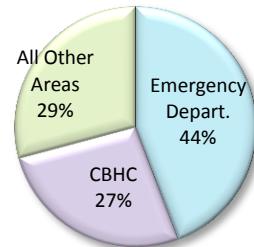
When coupled with gangs and the affiliated entourage who accompany a gunshot wounded member into the hospital, lengthy wait times due to continued overcrowding, and the everyday threats of caring of domestic violence, the emergency department is without question the most volatile area of the hospital.



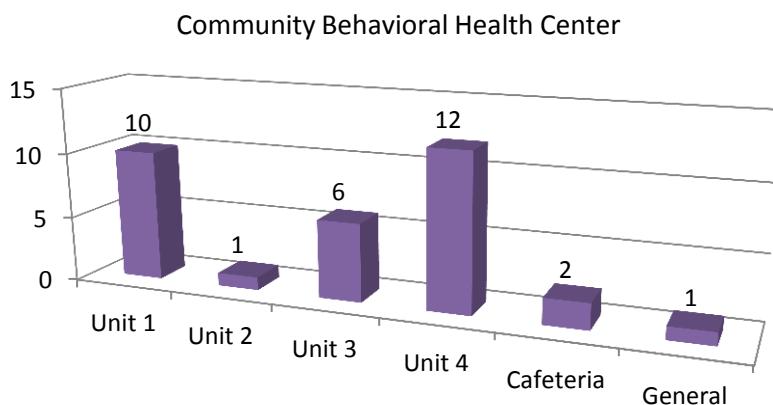
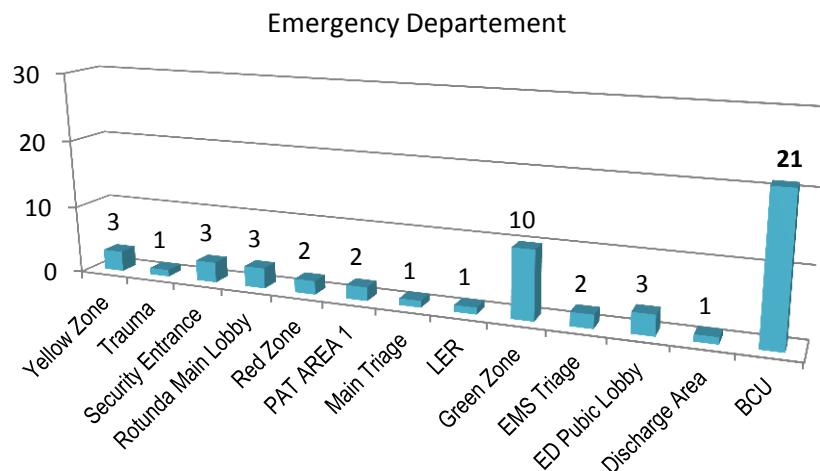
Areas of High Risk for Assault

The Emergency Department had the highest incidents of assault, followed by Community Behavioral Health Center. Of the 120 assaults reported to security in 2015, 71% (85) occurred in one of these two locations.

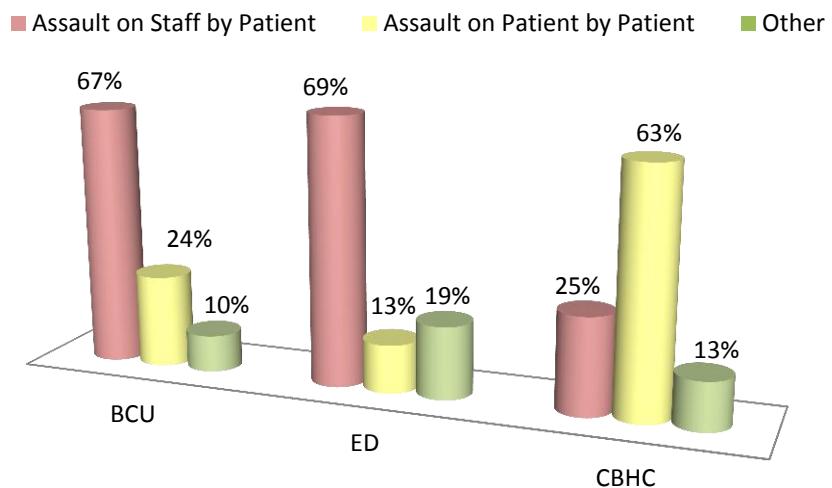
- Emergency Department
- Community Behavior Health Center (CBHC)



It is worth noting, that the Behavioral Care Unit (BCU) is physically located within the emergency department. For 2015, the BCU accounted for 40% of all emergency department assaults and 17% overall.

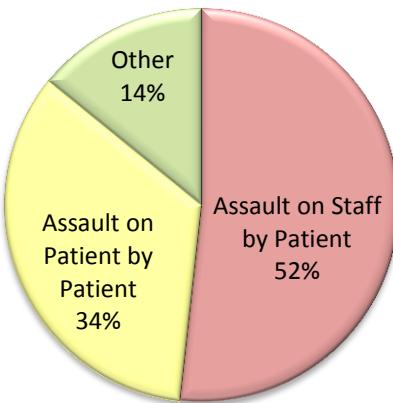


In the emergency department the majority of assault were perpetrated by patients on staff. However, at Community Behavioral Health Center, patient on patient assaults were most common (63%).



When combined, 52% of assaults at these locations were directed at employees by patients.

High Risk Locations by Victim



Current ED Security Safeguards

❖ Facility Design

- Ambulance entrance is separated from the walk in emergency entrance.
- Behavioral Care Unit is separated from other patient treatment areas.
- BCU patient property is secured away from the patients.

❖ Security Staffing

- Uniformed security officers maintain a 24 hr. presence in the emergency department.
- Security maintains fixed posts at public entrances, waiting rooms, behavioral care unit, ambulance entrance and interior spaces.
- Security Offices carry Tasers, pepper spray and baton.

❖ Electronic Safeguards

- Security equipment and systems are deployed throughout, including, electronic access control systems, video surveillance and panic alarms.
- Restrooms contain emergency patient notification devices.
- Property searches and metal detecting devices are used to screen persons entering the public waiting room.

❖ Training

- Emergency department and security personnel receive annual training in aggressive/violent patient management.
- Security personnel receive restraint application training and safe patient control and take-down tactical training.

❖ Policies and Procedures

- Security policies and procedures are in place, regarding security role in managing high risk patients to include, patient holds, searches and application of patient restraints.
- Color code visitor passes are used to manage visitor. Pass colors are rotated daily.
- The emergency department has implemented a high census access control protocol initiated during times of serious overcrowding or volatile emergency situations.

ED Vulnerabilities

❖ *Compartmentalization of Spaces*

- No physical separation between Public waiting room and Provider at Triage (PAT) treatment area.
- No physically barriers to separate treatment area from the waiting room during an emergency.
- Public entrance security station has no barrier to shield security personnel from intruders or gun fire.
- South East entrance door to the Emergency departments east corridor

❖ *Access Control*

- Entrance doors are prone to mechanical failures due to high use.
- Entrance doors can be pried opened by intruders.
- Internal waiting room door motion sensor is often unintentionally activated causing doors to open.

❖ *Overcrowding*

- Mental health and other high risk patients are often housed outside of the Behavior Care unit due to overcrowding.
- During periods of high census, patients are often housed in areas not designed or designated for patient treatment.

❖ *Electronic Safeguards*

- No electronic access control programing to rapidly lock down the emergency department.

❖ *Parking Lot*

- Inability to completely shut down vehicular access to the parking lot during emergency incidents, such as gunshot wound drop offs.
- No physical barriers, such as bollards, to prevent ramming of a vehicle into the building.

New Workplace Violence Regulations

The Occupational Safety and Health Administration (OSHA) recently began an extensive campaign to address workplace violence in healthcare. This followed the September 2014, CA State Legislature passage of Senate Bill (SB) 1299, which amended the Labor Code to create a new Section 6401.8. The new labor code required Cal OSHA to develop standards that require hospitals to adopt a workplace violence prevention plan by July 1, 2016.



This law requires healthcare organizations to develop a workplace violence prevention plan that covers all facilities and all departments within their organization. This law also created a new definition of workplace violence. Under this definition, an employee does not need to sustain an injury to be a victim of workplace violence. The following summarizes aspects of the new regulation:

Applicability

- ❖ Health facilities:
 - General Acute Care hospitals
 - Acute psychiatric hospitals
 - Special hospitals
- ❖ Other types of facilities
 - Outpatient medical offices and clinics.
 - Home health care and home-based hospice.
 - Paramedic and EMS including these services when provided by firefighters and other emergency responders.
 - Field operations such as mobile clinics and dispensing operations, medical outreach services, and other off-site operations.
 - Drug treatment programs.
 - Ancillary health care operations.

Plan requirements

- Annual education & training for all health care workers who provide direct patient care.
- Education & training must be designed to offer interactive questions/answers with a knowledgeable person
- A system for responding to, and investigating violent incidents and situations involving violence or the risk of violence
- Annual assessments to improve upon factors that may contribute to, or help prevent workplace violence.

New Workplace Violence Definition

- ❖ Workplace violence is defined as any act of violence or threat of violence that occurs at the work site and includes:
 - 1) The threat or use of physical force against an employee by a patient, a person accompanying a patient, other employees, or other person that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;

And

 - 2) An incident involving the threat or use of a firearm or other dangerous weapon including the use of common objects as weapons, regardless of whether the employee sustains an injury.

Workplace Violence Classifications

- Type 1 - with criminal intent, and includes violent acts by anyone who enters the workplace but has no legitimate business.
- Type 2 - directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services.
- Type 3 - against an employee by a present or former employee, supervisor or manager.
- Type 4 - committed in the workplace by someone who does not work there, but is known to or has a personal relationship with an employee.

Reporting

- ❖ Additionally, by January 1, 2017, Cal-OSHA is required to post a report on its Internet Web site containing information regarding violent incidents at hospitals that includes:
 - The total number of reports
 - Which specific hospitals filed reports
 - The outcome of any related inspection or investigation,
 - The citations levied against a hospital based on a violent incident
 - Recommendations of the Division on the prevention of violent incidents at hospitals.

In December 2015, OSHA launched a new webpage to provide strategies and tools for preventing workplace violence in healthcare. The webpage, part of OSHA's Worker Safety in Hospitals website, complements the updated Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, published earlier this year.

Infant & Pediatric Security

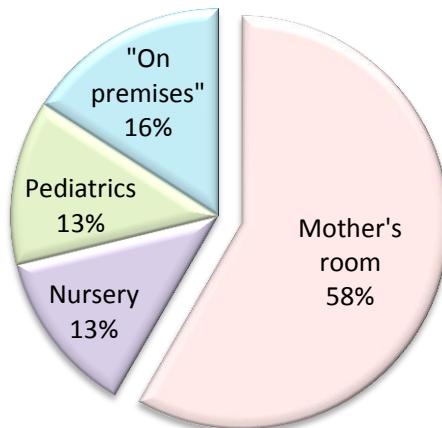
According to the National Centers for Missing and Exploited Children (NCMEC) since 1983, there have been a total of 300 documented non-family member infant abductions in the US.



NCMEC Newborn/Infant Abduction Stats:

- 44% of these abductions were from healthcare facilities (total of 132).
 - In 58% of these cases, the baby was taken directly from the mother's room.
 - Typically, these Abductors used deception to impersonate a nurse or other healthcare worker, to gain access to the infant.
 - California tops the list with 40 infant abductions followed by Texas with 38.
 - Of the CA abductions, 41% occurred from hospitals.
- Because it is easier to access a mother's room than the nursery and new newborns are spending more time with their mothers, most abductors "con" the infant directly from the mother's arms.

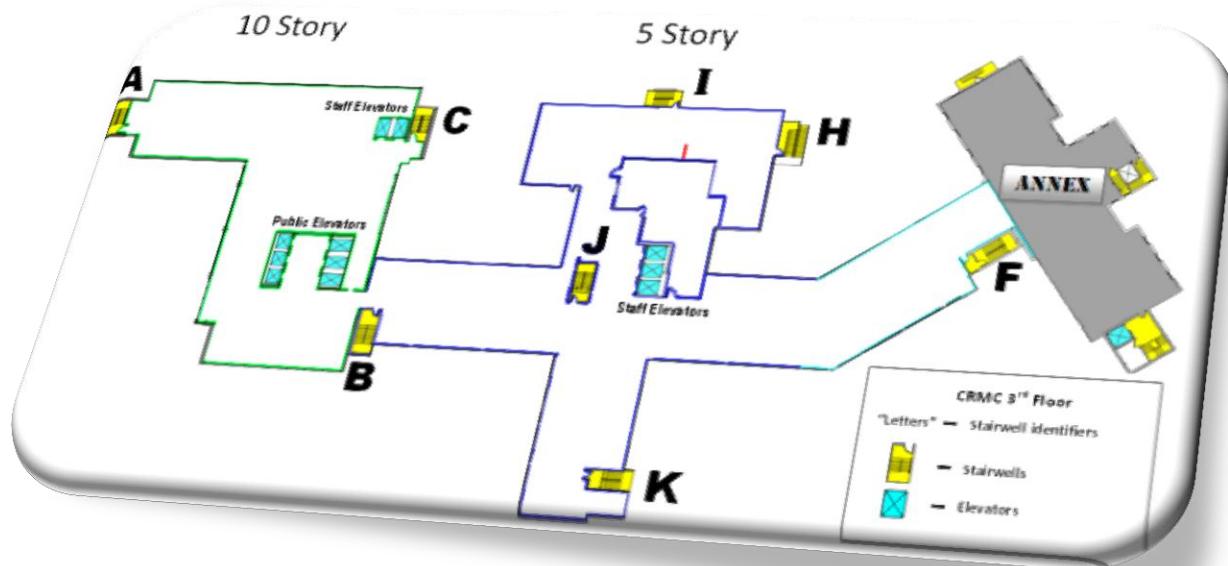
Hospital Infant Abduction by Locations



Assessment

The CRMC infant and pediatric units were evaluated in this assessment; specific elements include control points, circulation routes, egress paths and physical security safeguards.

- 3rd Floor:
 - Labor & Delivery (10 Story, 3 West)
 - Mother/Baby Post-Partum (5 Story, 3 Central & 3 East)
 - Level III NICU (5 Story, 3 Central)
 - 8 Stairwells (A, C, B, I, H, J, K, F)
 - 11 Elevators (2, 3, & 6 banks)
 - 1 entrance to adjacent business occupancy (Annex).
- 4th Floor:
 - High Risk NICU (10 Story, 4 West)
 - 1 Stairwell (K)
 - Secure Unit
- 5th Floor:
 - Pediatric Unit (5 Story, 5 Central)
 - 1 Stairwell (K)



Elements of the Infant & Pediatric Security

Over the last several years CRMC has made considerable efforts to prevent unauthorized access to the infant and pediatric units. Various elements of physical and electronic security systems have been deployed to the ‘harden the target’ against a would-be abductor. These security elements intertwine to provide a high level of access control and patient safety.

Identification

Immediately, after delivery matching identification bands are attached to all newborns and parents. Cord blood samples are drawn for all newborns and retained in the lab. Footprints are made within 2 hours of delivery and photographs of the infant are taken. However, these photographs are not uploaded into the infant’s medical record. Instead, the images are stored on digital camera memory card. A workgroup is currently working to address this issue, so that the images can be included in the medical record.



All employees are required to display their credentials, unobscured and clearly visible at all times. Hospital badges in Women & Children’s Service areas are identified by the color pink with the employees’ photo, name and department listed on the front. Although, staff badge photos are not regularly updated, this reduces their effectiveness as means of identification. Additional, the departmental unique identifiers are not changed at regular intervals, which make them vulnerable to counterfeiting.

Physical and Electronic Security Safeguards

Individuals, who come and go on these units, are carefully monitored. During visiting hours, all visitors are screened by a posted security officer prior to entering the maternity and pediatric units and are granted access on an individual basis. Security cameras have been installed in hallways, lobbies and inside elevator cabs. Access control devices integrated with badge swipe readers are installed at all stairwells and staff elevators. Illuminated electronic security signage, is posted and clearly visible to better delineate restricted areas. The access controls devices are augmented with audible alarms and intrusion detection programming, which is monitored 24 /7 by the onsite Security Dispatch Center.

Even with these controls and access restrictions, our physical security strategy is not without limitations. This is particularly true, when it comes to preventing a potential abductor from leaving the unit. Because of Fire Code provisions, all stairwells on the 3rd floor cannot be locked. Thus, even though we are alerted to a security breach, the unimpeded egress effectively neutralizes our ability to prevent a would-be abductor from rapidly fleeing the unit with an infant or child.

Electronic Infant & Pediatric Monitoring

Currently, CRMC is in the process of installing an Active Radio Frequency Identification (RFID) tagging system on the Infant and Pediatric Units. The system consists of radio transponders that clamp to the infants umbilical cord, so that the infants’ location can be tracked from the nurses’ station effectively becomes part of the protection zone, rather than simply being inside it.

The infant tagging system will provide a new level of deterrence to the current infant protection strategy. Having greater insight into the nature of an Infant Security alarm, will allow greater scrutiny and a more balanced emergency response. The system is also expected to reduce nuisance alarms, saving time, money and improve patient satisfaction. More importantly, the system is expected to have a considerable impact on alarm fatigue brought on by excessive nuisance alarms and thereby improve patient safety. Alongside the existing security infrastructure, the *RFID* tagging system will serve as a force multiplier and dramatically increase our security capabilities.



Delayed Egress Electronic Locks

The infant/pediatric tagging system is an important step in meeting our security objectives, but it addresses only one aspect. The broader concern, of perimeter security and alarm fatigue brought on by excessive nuisance alarms, still needs attention. In hospitals, it is common to install *RFID* tagging systems alongside delayed egress locks as part of the overall, maternity protection strategy. The NCMEC considers delayed egress locks an essential physical security safeguard and recommends installing them on all stairwell exit doors to/from maternity, NICU, and pediatric units. On these units it is understood that the security needs of the patients, require a certain level of delay in an unauthorized individual trying to flee the unit. The subsequent delay is instrumental in alerting staff that an unauthorized person is attempting to leave but more importantly, hindering that person's ability to do so.

What's more, is the impact delayed egress will have on the excessive nuisance alarms. No longer will unwary employees or visitors be able to unintentionally activate an alarm. We predict that following the installation of delayed egress locks, our monthly nuisance alarms will drop significantly. As evidence of this assertion, we need only look to the dramatic effect that delayed egress locks has had on the NICU.

Prior to the installation of delayed egress locks the NICU experienced 16 '*Code Pink*' false alarms (*January through April 2012*). That number dropped by 80% in the preceding months, resulting in only 3 false alarms for the remainder of that year. Taken together, our existing security infrastructure, the *RFID* tagging system and the proposed delay egress locks, will dramatically increase our security capabilities.

Regulatory Hurdles

In 2013 CMS issued several categorical waivers which authorized hospitals the option of taking advantage of certain provisions of the 2012 LSC, even though, this version has not yet been formally adopted. CMS permitted a waiver to allow door locking arrangements, where there are clinical needs to justify them such as, patients who pose a security risk, or who require specialized protective measures for their safety (e.g., pediatric units, newborn nurseries).

While CMS and the Joint Commission, permit the use of delayed locks for infant security purposes; the California Fire Code does not. In 2014, CRMC sought approval from the Fresno City Fire Department to install delayed egress devices on the maternity and pediatric units. However, this request was denied. There are indications that the CA Fire Code may align with the Life Safety Code, although this remains to be seen.

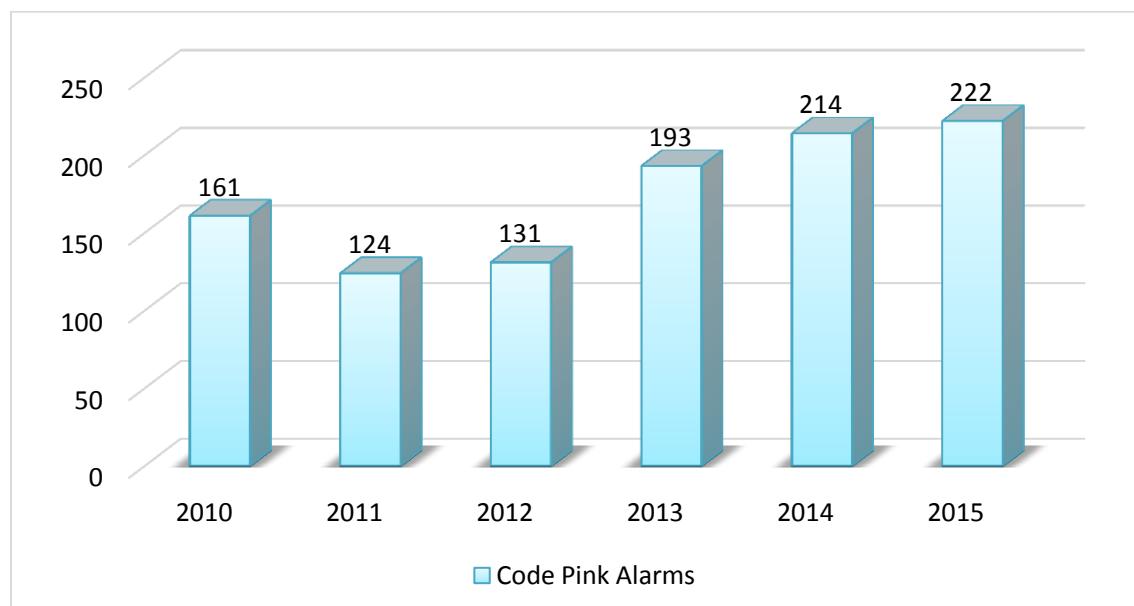
Code Pink Alarm Trends

Currently, badge readers, audible alarms and intrusion detection configurations, are deployed to alarm in the event of an unauthorized opening of a stairwell door. This configuration allows authorized staff access into the stairwell or onto the floor from the stairs, via their access badge. If the door is opened without first presenting this credential an alarm will sound.

This configuration provides a basic level of emergency notification, but provides no intelligence into the nature of the breach. Without means to differentiate between an intentional security breach and an accidental alarm, staff must assume the former and initiate the emergency '*Code Pink*' response protocol. As a result, CRMC experiences a high number of false alarms.

Over the last 5 years, Code Pink alarms have continued to increase. In 2015 there were 222 '*Code Pink*' false alarms and although, this was an increase over the prior year, the growth rate slowed to 4% when compared to the prior year.

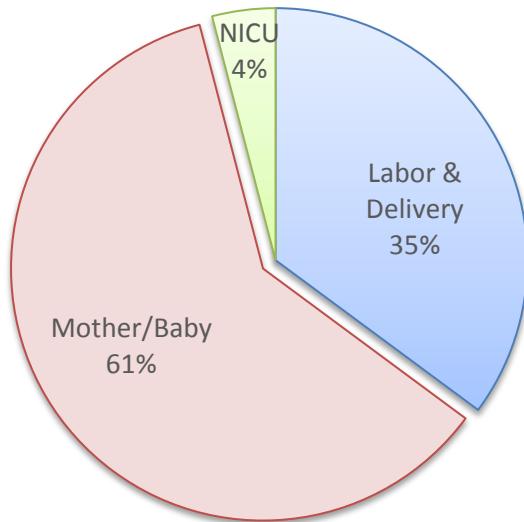
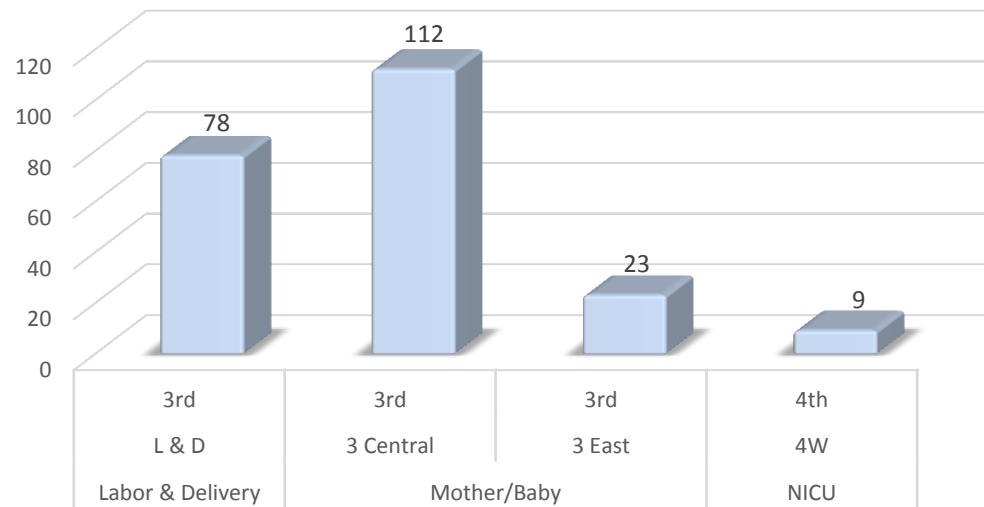
Year	YTD	Change from Prior Year	% Change from Prior Year
2010	161	NA	NA
2011	124	-37	-23%
2012	131	7	6%
2013	193	62	47%
2014	214	21	11%
2015	222	8	4%
Average	174		



Where Code Pinks Occur

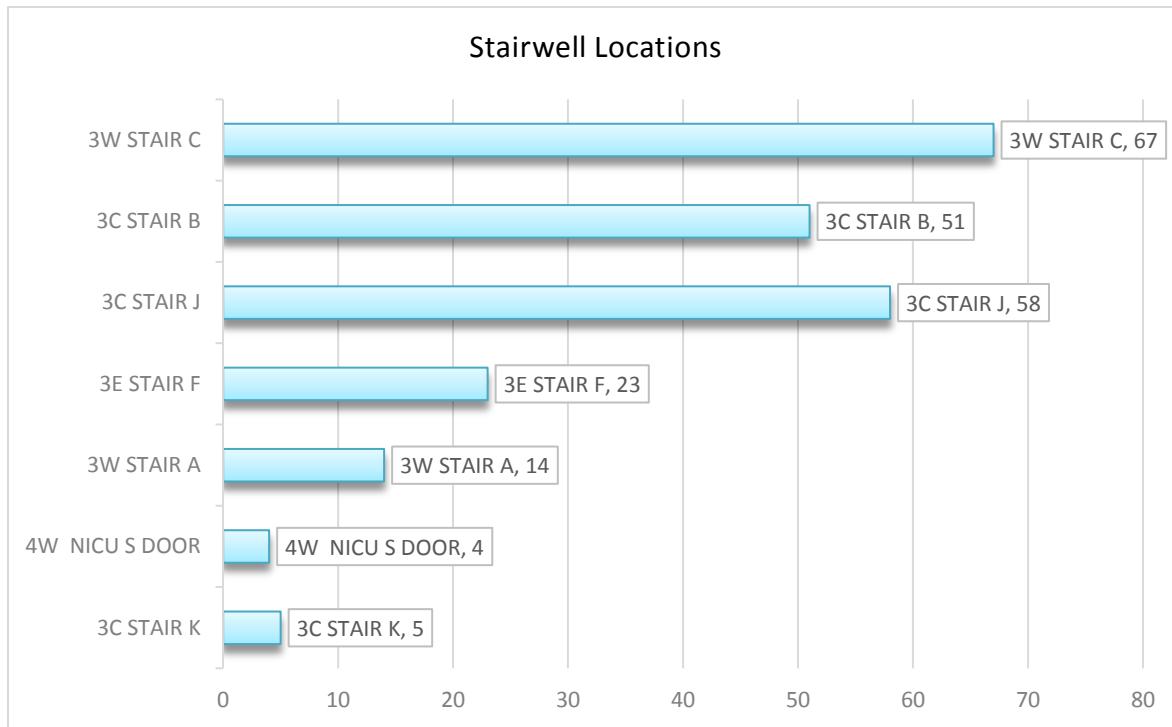
An analysis of Code Pink alarms, show the majority originate on the 3rd floor. 61% of all alarms originated on PNU (Mother/Baby).

3rd Floor by Area



Stairwells

L&D's Stairwell "C", had the greatest number of activations in 2015. Historically, inattentive employees', failing to swipe their badge prior to opening an alarmed stairwell, is the leading cause of all Code Pink Alarms. In other instances, visitor's unfamiliar with the facility, failed to heed warning signs and accidentally trip stairwell alarms as they attempt to leave the unit.

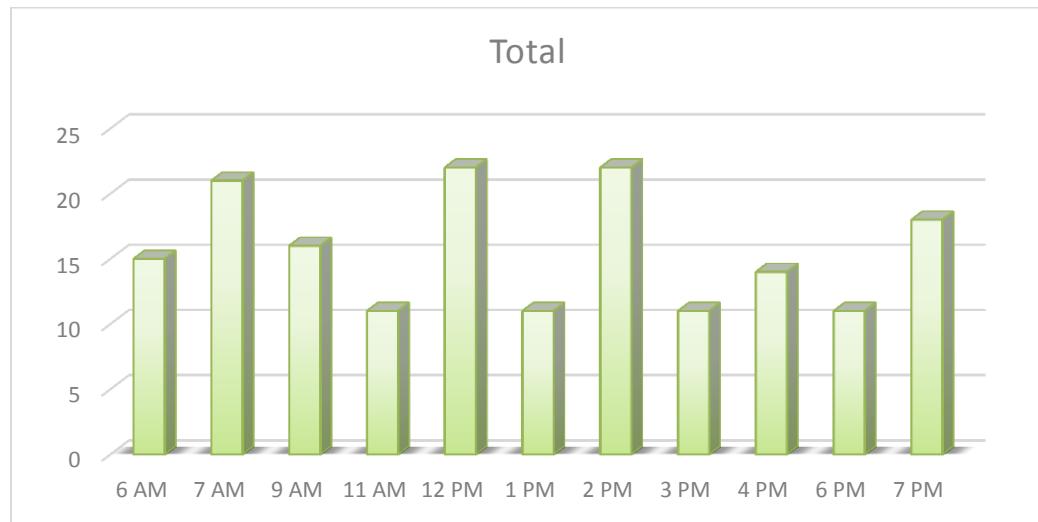
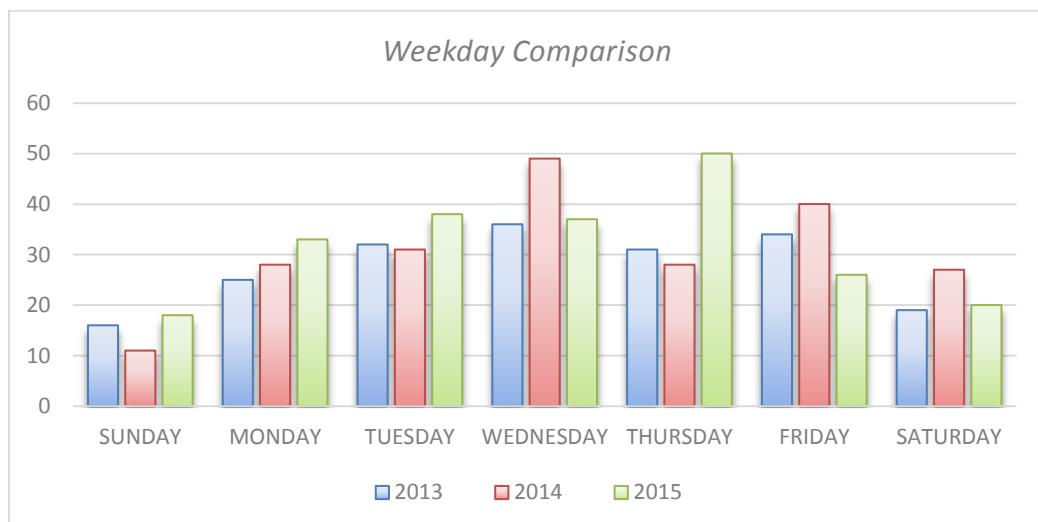
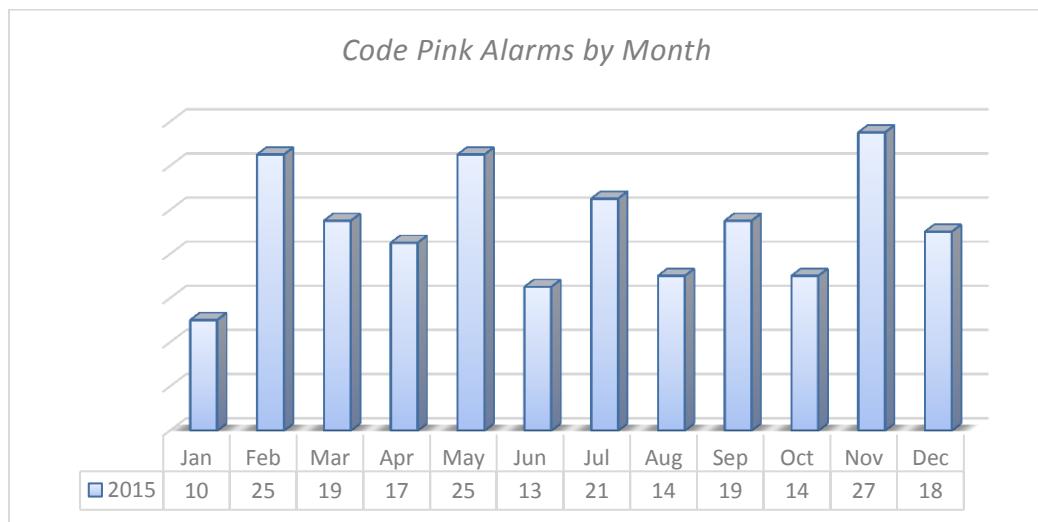


Cost of Code Pinks Alarms

A typical '*Code Pink*' response cost the organization approximately \$450, per incident. This calculation was factored based on the total number of staff need to adequately monitor corridors, elevators and exits, multiplied by an average employee wage.

For 2015, the average Code Pink Alarms took approximately 7 minutes to resolve. Thus a total of 26 hours for the year, were devoted to Code Pink alarms response. Based on the current average of 19 incidents per month, these costs total about \$8,500 per month. The approximate cost of Code Pink alarms for 2015 amounted to \$99,900.

When Code Pinks Occur



Assessment Summary

Vulnerabilities:

- Warehousing of infant identifications photos.
- Outdated staff photo identification badges.
- Lack of updates to the department specific unique badge identifier.
- Unimpeded stairwell means of egress.
- Lack of intelligence into cause of Code Pink alarm (intentional vs. accidental).
- Staff complacency attribute to high numbers of false alarms.

Recommendations:

1. Establish a process whereby infant photos are uploaded into their medical record.
2. Establish a policy/procedure which requires all pediatric, infant and NICU to update their badge photo at a predetermined interval. A new version of the current access control system is expected in 2016. With this version, a badge can be pre-programed to expire at a predetermined interval, which then requires the employee to take a new photo.
3. Every 3 years, alter the unique department badge identifier (color, watermark, etc.) for all infant, pediatric and NICU departmental staff to minimize the potential for counterfeiting.
4. Require infant cord blood samples to be retained for at least 24 hours after patient discharge.
5. Complete the installation of the RFID Infant/Pediatrics security tagging system.
6. Submit a formal request to the California Office of Statewide Health Planning and Development (OSHPD) agency for approval to install delayed egress locks on all L&D, PNU and Pediatrics Unit stairwell doors.

Glossary of Terms

1. **Crime Prevention Through Environmental Design (CPTED)** - Crime determent strategy which emphasizes the proper design and effective use of a designed and build environment. Fundamentals include the use of concentric rings of protection, starting with the property perimeter and moving inward, protection layers are strengthened each layer.
2. **CAP Index CRIMECAST Report** - Crime risk forecasting methodology which correlates the relationship between a neighborhood's "social disorder" to the amount of crime perpetrated there. The report uses various analytical statistical measurements to objectively assess a sites risk of crime in comparison to national, state and county averages.
3. **Posted Security Officer** - Area or location is directly supervised by the presence of a physical security officer, on a full or part time basis.
4. **Access Control Devices are in use** - An access control lock may utilize a magnetic or electric lock assembly, and is often integrated with the badge swipe reader to control access into an area. A motion senor is mounted on the egress side of the door, detects a person approaching and automatically unlocks the door in the direction of egress. These devices are capable of centralized monitoring and have a wide range of programming functionality. Locations with these systems are generally considered more secure than locations without these controls.
5. **Access Controls are appropriate for location** - Given the intended purpose and location of the area; are the security controls, systems or features sufficient to effectively alert, prevent or discourage a security breach.
6. **Direct Surveillance Camera Coverage** - Location is supervised by a surveillance camera which supports remote electronic monitoring of the area or location.
7. **Indirect Surveillance Camera Coverage** - Location is not directly supervised by a surveillance camera, however, the location is observable with the use of camera located in the vicinity of this area or location.
8. **Door has Lock** - Location has a door which can be locked, regardless of whether or not the lock is in use.
9. **Lock has Primus Core** - Given the age of the facility, locks pose a security risk resulting from unauthorized key duplication. Schlage Primus keys are engineered to ensure a standard key will not enter a Primus cylinder. Doors outfitted with the Primus security cylinder system are more secure. Dead bolt locks are not permitted in the path of emergency egress because they require more than one releasing action to operate the door.
10. **Local Alarm** - A local alarm system is an auditable alarm that sounds at the location indicating that a breach has occurred. These alarms may or may not be monitored by a centralized monitoring station. In some cases, these alarms do not have the mechanical or technical features necessary to be integrated into a central monitoring station.

11. **New Security Local Alarms** - A location with a hardwired DSI Local Alarm. This style of alarm has a door prop and exit alarm. This alarm is often equipped with a tamper proof on/off switch and is capable of centralized monitoring. In contrast to a battery operated model which has no monitoring capacity and is prone to failure due to battery drain.
12. **Burglar Alarm** - A system designed to detect unauthorized entry into a building or area. Various Sensors are used to monitor activity and access in and out of the area. These alarms require the use of a security code to active/deactivate the system and are supported by a central monitoring station. Areas or locations without a burglar alarm are not penalized in this category.
13. **After hour's coverage** - Area or location has staff present during overnight or after hour's operations.
14. **CCURE Event** - A systems access control programming configuration designed to initiate routine and non-routine security actions, and to alert users of security violations. Events are commonly used to lock and unlock doors, sound alarms, and initiate CCTV camera actions following a security breach. Areas or locations with no CCURE scheduled event are not penalized in this category.
15. **Adequate Lighting** - Lighting in location or area is or is not sufficient to deter or to effectively monitor persons or activities. Are there adequate fixtures that are sufficiently illuminated and in proper working order?
16. **Correct Level of security feature** - Given the intended purpose and physical location of the area, are the security controls, systems or features sufficient to effectively alert, prevent or discourage a security breach.
17. **Adequate Design for Security Purposes** - Does the location affectively segregate authorized and unauthorized visitors? Are the appropriate physical and psychological barriers and hardware in place to effectively secure the area or location?
18. **Door has Handle or Key Core** - A door with a handle and lock mechanisms may be subject to mechanical failure or physical tampering. Therefore, locations with these features may be less secure than a door with none of these external mechanical features.
19. **Door is Emergency Egress** – An exit door designed to allow the occupants of a building to evacuate safely during an emergency. All locks must be unlockable using a single motion from inside the room. A separate deadbolt and latch are not permitted, as they would require more than one action to unlock.
20. **Remote location** - A location that is not frequented by staff or visitors. The location may be subject to infrequent access depending on the time of day or day of the week. For example, an area or location might be regularly used during business hours, but have considerably less traffic during the overnight or weekend hours.
21. **Door can be easily opened from outside** - Locations that provides access into the facility, may not by themselves pose a significant security risk. For the purposes of this evaluation it was necessary to differentiate between locations that are not easily accessible (primarily from the outside) and that those that provide free and obstructed access into the facility.

22. **Door is frequently used** – Location is frequently utilized by personnel for ingress or egress purposes.
23. **Freely or easily accessible to Public** - A location that is generally open to or accessible by the general public (pedestrian or vehicular traffic) regardless of the intended purpose.
24. **Frequently accessed after hrs.** - An area or location that is frequented by staff, patients or visitors during overnight hours.
25. **Limited or No weekend staffing** - The area or location has limited or no staff presence from the end of business on Friday until the beginning of business on the following Monday.
26. **24 hr. Visitation** - Area or location is impacted by the general public seeking treatment or visitation of patients. Due to this circumstance, the location may be directly or indirectly accessibility to the public, regardless of security access controls or protocols.
27. **Staff habits compromise security** - Habitual habits practiced by staff that contributes to an unsafe and unsecure environment, which puts themselves or others at risk. Are staff conscious of their surroundings? Do they use good security practices, such as properly securing doors, windows and screen patients or visitors, when appropriate? Does staff deliberately defeat security devices or controls for the purposes of self-serving purposes?
28. **Few staff or alone** - Staff in the area or location are alone or few in numbers.
29. **Probability** - Regardless of this locations intended purpose, is this location vulnerably to a security breach. Factors under consideration are past history of security incidents, types of services provided (emergency medicine, behavioral care, etc.) ease of access or any other circumstance which presents a significant security concern, either real or perceived.

*Community Regional Medical Center
Security Services
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