BACKGROUND/CONTEXT
• Modes of Transmission/Aerobiology
• ASHRAE Statements on Airborne Transmission
• CDC recommends Airborne Infection Isolation rooms for aerosol generating procedures (AGPs)
• Committing Airborne Infection Isolation rooms for use as inpatient rooms limits future flexibility. Work with clinical staff to establish use requirements.
• Cohorting – Cautions and current methods.
• See ASHRAE COVID-19
• ASHRAE members have provided input on Disaster Planning and Emergency Management for Healthcare Facilities. Partner on your local professional engineering partners for input and guidance during this time.

GOALS
• Do No Harm
• Protect Healthcare Workers, Family, and Visitors
• Protect Other Patients
• Empower people to make and carry out the best decision they can.
• Work as a team – weigh competing concerns, define key areas, share the plan.
  • Consider the type of HVAC system, the configuration, clinical needs, facility infrastructure capacity, and limited resources available.

LIFE SAFETY
• Confirm that power-consuming equipment is connected to the appropriate branch of the essential power system.
• Maintain Egress
• Consider defend-in-place plans and smoke compartments
• Increased facility oxygen use elevates risk of a fire spreading more rapidly
• First responder protection.
• Develop Interim Life Safety Measures as applicable

SUGGESTED APPROACHES
• Passive Isolation
• Strategically utilize All Rooms
• Airflow from Clean to Less Clean
• Increase Filtration Level if possible
• Eliminate recirculation or minimize to the extent possible
• Maintain relative humidity at 40–60%.
• Deactivate or by-pass heat recovery wheels
• Improve/Consider room airflow direction/patterns
• Utilize portable ante rooms/vestibules with HEPA filtration
• Utilize UV light (see Facilities/Maintenance – Disinfection)
• Areas for non-Covid patients should still be treated with care because someone could be unknowingly infected.

SPECIFIC "HOW-TO" AND UNIQUE AREAS
• Layered approach for normal and small surge operations
• Source Control Options for patient beds
• Operating on COVID-19 positive patient
• Variable Air Volume Adjustments & Modification to economizer or reduced recirc.
• Cautions on Recirculating Room Units (Fan coils, induction units, etc.)
• 2-person patient rooms – creating or managing existing
• Use Operating rooms for inpatient rooms/temp ICU
• Emergency Department
• Warning on Older ICU units
• Transmission through the air in toilet rooms
• Provide areas for safely doffing PPE, such as shoe cover removal followed by “tacky matts” for personnel exiting an area.
• Gastrointestinal Endoscopy

SURGE AREAS
• Initial Considerations
• Alternate Care Site Design Concepts
• Single patient room considerations vs. 2-patient rooms
• General Parameters for ACH, Temp, Filtration, and RH

FACILITIES/MAINTENANCE
• PPE basics
• Filter changing
• Room turnover
• Verify performance of critical HVAC systems – airborne infection isolation rooms, Emergency Departments, etc.
• Disinfection: Normal, UV, VHP, Hypochlorous Acid
• See ASHRAE COVID-19 Filtration and Disinfection section for greater detail.
• Considering the possibility of being short-staffed in the future, run-test and re-fuel emergency generator system.
• Submit waivers as required to CMS for inspection, testing, and maintenance under Section 1135. ASHE Template.
• Check to be sure COVID-19 area AHU return air isn’t being used to condition mechanical rooms.

MEDICAL GAS/VACUUM SYSTEMS
• Demand for gasses in ICU rooms
• Demand for gasses in med-surg rooms and OR’s
• Accommodating increased demand (flow) in fixed piping systems
• Impact of demand/consumption on existing gas systems
• Consider providing supplementary gas sources

OTHER
• Utilize make up air units or exhaust fans from other facilities (restaurants) that are currently shut down.
• Reduce # of rooms utilized off a single HVAC system to free up AHU capacity to achieve performance goals. 25 beds with desired airflow/temps better than 30 beds with airflow/temp deficiencies.
• Document the Action Plan and Alternations in Place
Modes of Transmission

• SARS-CoV-2, the virus that causes COVID-19, is thought to spread mainly from person-to-person through respiratory droplets. Recent research indicates that SARS-CoV-2 is resilient in aerosol form and may be a more important exposure pathway than previously considered.


• Infectious respiratory droplets are produced when an infected person coughs or sneezes.
  − Droplets can land in the mouths or noses of nearby people.
  − Droplets can land on surfaces and be spread through contact with contaminated surfaces.
  − When in close contact with an infected person, droplets can possibly be inhaled into the lungs.

• Recognize That Virus May Be Aerosolized During Toilet Flush.

• Keep plumbing traps full of water to avoid transmission of air through dry traps.
Airborne Transmission

ASHRAE Statement on airborne transmission of SARS-CoV-2

- Transmission of SARS-CoV-2 through the air is sufficiently likely that airborne exposure to the virus should be controlled. Changes to building operations, including the operation of HVAC systems can reduce airborne exposures.

ASHRAE Statement on operation of heating, ventilating, and air-conditioning systems to reduce SARS-CoV-2 transmission

- Ventilation and filtration provided by heating, ventilating, and air-conditioning systems can reduce the airborne concentration of SARS-CoV-2 and thus the risk of transmission through the air. Unconditioned spaces can cause thermal stress to people that may be directly life threatening and that may also lower resistance to infection. In general, disabling of heating, ventilating, and air-conditioning systems is not a recommended measure to reduce the transmission of the virus.
Aerosol Generating Procedures

It is possible that the virus is spread through aerosol, so minimize aerosol generating procedures.

- positive pressure ventilation (BiPAP and CPAP)
- endotracheal intubation
- airway suction
- high frequency oscillatory ventilation
- tracheostomy
- chest physiotherapy
- nebulizer treatment
- sputum induction
- Bronchoscopy
Cohorting: Cautions and Current Methods

• Clinicians have advocated against cohorting suspected and confirmed patients to avoid the potential for conversion. Coordinate with your clinical staff in this manner.

• Do designate specific area outside or in ED for respiratory cases
  – In order to manage patient influx, congestion and to control the risk of exposure to healthcare workers, hospitals are restricting access to Emergency Dept to ambulatory patients only and designating a specific area in ED for respiratory cases.

• Do triage Persons Under Investigation (PUI) capable of self-care outside the ED, either through drive-through or walk up screening stations set up in tent or temporary space, and advise continuing home care until results are available.

• Do consider designating entire units to care for COVID patients.
  – Conserves PPE
  – Improves containment
Alternate Care Sites

Clinical Goals Will Dictate Infrastructure Needed

• Determine if space is for COVID-19 Confirmed, suspected, or non-COVID-19 Patients and at what acuity level. Do not cohort suspected & confirmed patients. Consider locations for staff respite areas.

• Consider Liability Issues If Diverging From FGI/State Guidelines
  – ASHE Note: During emergencies, it is important that activities be coordinated through the organization’s incident command system. Activities outside of an organization’s command structure should be coordinated with the local, county and state incident command systems. This enables effective and efficient incident management within common organizational structures.

New CDC/NIOSH Info on “Expedient Patient Isolation Rooms”

Suggested locations to consider for COVID-19 surge space:

• Ambulatory Surgery Centers
• Operating Rooms
• Administration areas that used to be patient space
• Consider areas served by the same AHU, on the same floor, within a single “suite”, or within the same smoke zone.

• Links to Images/Concepts for surge space

Concepts for sites, including schools, parking garages, hotels, etc. can be found through this ASHE website:

• Converting alternate care sites to patient space options
Alternate Care Sites

Issues to Plan for and Address:

• **Staffing** - Adequate Skilled Care Providers and Support Staff
• **Supplies** - PPE, Beds, Equipment, Infrastructure including HVAC, Power, Internet Access
• **Space** - Site Evaluations and Proximity to Hospital and Areas of Demand
• **Do Not Ignore Access to Toilets and Hand Washing** (Challenge at Large Volume Spaces Like Convention Centers). Common toilet areas could contribute to transmission and viral load.
• **Changes in climate over time that may stress system capacity.**
Consider exhaust discharge locations – direct away from people and outside air intakes.

Bottom opening exhausted to create front to back airflow across patient.
Alternate Care Sites

Below are some general parameters for air changes per hour (ACH), temperature, filtration, and relative humidity for non-COVID emergency surge spaces outside of a licensed hospital.

- Minimum 2ACH Outdoor air and 2 ACH Total air, though higher total air is desired (basis is patient room from FGI 1997).

- For large volume spaces with high ceilings, such as conference centers, air changes may be calculated based on a ceiling height of 10 feet, however for supply air temperatures above room temperature, minimum OA and total ACH may be calculated as 2ACH Outdoor divided by 0.8 ACH, or 2.5 Total air, (ASHRAE 62.1 ventilation effectiveness) and supply air temperatures kept no more than 15 degrees F above room temperature to minimize stratification and short circuiting of air within the space.

- No less than MERV 13 and MERV 14 preferred for systems that are not serving specialized environments that may require even higher efficiency filtration.

- Temperature 70 – 75 degrees F

- Humidity – Recommend 40-60% RH

- Refer also to Minnesota Department of Health, “Methods for Temporary Negative Pressure Isolation”
Suggested Approaches

Most Basic Approach: Passive Isolation per CDC Guidance

- One Patient per Room
- Close the Door
- Implement Related CDC Safety Protocols

• Work with clinicians, anticipate patient load, and establish layered approach as needed.

Strategically Utilize Airborne Infection Isolation Rooms

• Consider utilizing one Airborne Infection Isolation Room for intubation/extubation with one anesthesiologist to conserve PPE
Suggested Approaches

Airflow from Clean to Less Clean

• More important than having to wait a longer time between room changeover due to lower ACH
• More important than air change rate
• More important than outside air % above 2ACH

Increase Filtration Level if Possible

• Consider reduced airflow impacts from higher pressure drop that could lead to loss of desired room pressure differentials. Can the fan be speed up?
  - Increase frequency on VFD
  - Sheave change if belt driven
• Take care not to allow the fan motor power input to exceed its rated capacity.
• Watch for difficulty with the filter seal due to higher pressure drop across filter.
Eliminate Recirculation or Minimize to the Extent Possible

Utilize this approach only as part of a specific surge plan

- Protect equipment from freezing – water coils, DX
- Watch for condensation
- Consider relaxing temperature setpoints indoors
- Consider future condition when weather becomes more extreme before surge has passed
- Re-confirm ability to achieve desired room pressure differentials.
- Watch for operational stability of the fan(s) and adjust to achieve desired airflow.
  - Adjust frequency on VFD
  - Sheave change on belt driven fans.
  - Take care not to allow the fan motor power input to exceed its rated capacity.
Consider Maintaining 40-60% RH

Optimal relative humidity continues to be an area of active research.

- Dry air below 40% RH has been shown to:
  - Reduce healthy immune system function (respiratory epithelium, skin, etc.)
  - Increase transmission of some airborne viruses and droplets (COVID-19 still being studied)
  - Increase survival rate of pathogens
  - Decrease effectiveness of hand hygiene and surface cleaning because of surface recontamination or too-quick drying of disinfectants
  - For references to the above research, see those listed in this document.

- Take care if restarting older humidifiers to confirm proper moisture absorption in the airstream.

- Watch interior spaces to confirm no condensation is occurring, which would permit mold and moisture issues.

- Climate-Informed HVAC Increases in Relative Humidity May Fight Pandemic Viruses

- Reducing economizer operation is not recommended to improve minimum RH if it means losing negative pressure in rooms or losing once-through airflow.

- ASHRAE Tech Hour: Optimize occupant health, building energy performance, and revenue through indoor air hydration
Suggested Approaches

Deactivate or bypass heat recovery wheels, if the wheel leaks, in areas with COVID-19 patients.

- Look for these systems in Dedicated Outside Air Units, Energy Recovery Ventilators, and once through units
- Prevent contamination of heat recovery system components
- Utilize HEPA filtration prior to the heat wheel or discharge patient room exhaust directly outdoors instead of to the heat wheel or energy recovery ventilator.
- Evaluate how this will impact heating and cooling capacities of the system
  - Supplement with temporary heating or air conditioning
- For cross-flow heat exchangers, evaluate ability to adjust damper on bypass to increase outside air as much as possible.
Suggested Approaches

Improve/Consider room airflow direction/patterns.
Look at Ventilated Headboards to capture patient-generated aerosols closer to the source. New video from CDC/NIOSH of construction and research validation of ventilated headboard.

• Removal of Airborne Contamination in Airborne Infectious Isolation Rooms.
• CFD Analysis of Hospital Operating Room Ventilation System Part I: Analysis of Air Change Rates. ASHRAE Journal Vol. 60, no. 5, May 2018
• CFD Analysis of Hospital Operating Room Ventilation System Part II: Analyses of HVAC Configurations. ASHRAE Journal, Vol. 60, no. 6, June 2018
• Analysis of Spread Index: A Measure of Laboratory Ventilation Effectiveness. ASHRAE Conference Paper for the ASHRAE Annual Conference, Houston, TX. 2018
Utilize portable ante rooms with HEPA filtration

When We Refer to a “HEPA Unit” here are some examples:

- Portable HEPA Machine
- Pre-Assembled System

Ad Hoc Assembly

- HEPA Filter in Frame, Preferably Bag In/Out But As Needed/Available
- Off Shelf Exhaust Fan and Associated Power
- Sealed Connections, Rack or Wheel Mounted
HEPA Filters

- Yes, virus particles can be 0.1 micron or smaller.
- Particles and droplets generated by respiration, talking, etc. and by **Aerosol Generating Procedures**, and possibly toilet flushing are typically much larger than 0.1 micron.
- By definition, HEPA is at least 99.97% effective for 0.3 micron particles in standard tests (see chart).
- Efficiency is better than MERV 16.
- Filters are often delicate and require careful handling to preserve performance.
- HEPA is an effective tool for contaminant removal.
Facilities/Maintenance – PPE

PPE Basics

• Refer to [CDC Guidance on PPE use](#), especially banners at bottom of webpage.
• N95 masks require fit testing and a competent pulmonary efficiency.
• N95 masks are tested with 0.3 micron particles.
  – certified to filter at least 95% of airborne particles.
• N95 masks are an effective tool for worker protection.
• Sterilize for Reuse
• [Tool by NIST to support re-purposing rooms for VHP for mask disinfection](#).
• Don’t forget vinyl gloves, goggles/eye protection, shoe covers, and disposable coveralls or bunny suits.
• After maintenance activities, wash hands with soap and water or use an alcohol-based hand sanitizer. Change clothes if soiled.
• Consider Re-Use: Silicone Half Mask with N95
• Double Glove Increases Protection When Re-Using Gear
HVAC System Maintenance and Filter Replacement during the Pandemic

• For HVAC systems suspected to be contaminated with SARS-CoV-2, it is not necessary to suspend HVAC system maintenance, including filter changes, but **additional safety precautions are warranted**.

• The risks associated with handling filters contaminated with coronaviruses in ventilation systems under field-use conditions have not been evaluated.

• Workers performing maintenance and/or replacing filters on any ventilation system with the potential for viral contamination should wear appropriate **personal protective equipment (PPE)**:
  - A properly-fitted respirator (N95 or higher)
  - Eye protection (safety glasses, goggles, or face shield)
  - Disposable gloves

• Consider letting the filter load up further than usual to reduce frequency of filter changes.
  - Don’t let pressure drop increase enough to disrupt room pressure differentials.
  - Confirm filters remain snug in their frames.

• When feasible, filters can be disinfected with a 10% bleach solution or another appropriate disinfectant, approved for use against SARS-CoV-2, before removal. Filters (disinfected or not) can be bagged and disposed of in regular trash.

• When maintenance tasks are completed, maintenance personnel should immediately wash their hands with soap and water or use an alcohol-based hand sanitizer.
Filter Changing in units serving COVID-19 patients

- Consider letting the filter load up further than usual to reduce frequency of filter changes.
  - Don’t let pressure drop increase enough to disrupt room pressure differentials.
  - Confirm filters remain snug in their frames.

- Follow PPE Basics.

- Turn off AHU if possible. If not possible, consider wearing a bunny suit as additional PPE.

- Virus life on a filter is a function of temperature and relative humidity. Many folks utilize a fixate on the filters before they remove them. Spray with Lysol to disinfect and then use something like hairspray (spray paint works almost as well) to fixate.

- Bag the filter. It’s OK to throw out in regular garbage.

- Guidance for Filtration and Air-Cleaning Systems to Protect Building Environments from Airborne Chemical, Biological, or Radiological Attacks
Facilities / Maintenance

• Ventilate the Room and Terminal Clean before Re-use
• Follow CDC Air Change Clearance Rates (note these assume perfect mixing):

<table>
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<th>ACH $ \downarrow$</th>
<th>Time (mins.) required for removal 99% efficiency</th>
<th>Time (mins.) required for removal 99.9% efficiency</th>
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<tr>
<td>50</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>
Disinfection

• Priority on Normal Manual EVS Activities for Terminal Disinfection

• UV Air Cleaning
  • UV systems installed in air handlers can control biofouling of cooling coils. These systems are generally not likely to eradicate virus in the airstream unless designed to deliver the necessary dose during the available exposure time. Such systems require a much higher UV output.

• UV-C Disinfecting Lighting
  • Upper air UV light fixture can eradicate airborne virus; would not impact droplets settling on surfaces so there is limited impact on overall virus transmission.
  • Most direct UV lights are harmful to occupants and furnishings so there are limited applications.

• Some facilities decided to use vaporized hydrogen peroxide (VHP) disinfection, which requires careful application. Consult the system manufacturer for additional considerations.
  • Seal HVAC to room being treated and arrange for full space purge and testing before re-occupying.
  • May be better utilized for equipment rather than room sterilization. Tool by NIST to support re-purposing rooms for VHP for mask disinfection.

• Bi-Polar Ionization Air Cleaning
  • High voltage electrodes create reactive ions in air that react with airborne contaminants, including viruses. This process is commonly termed "corona discharge." A convincing body of scientifically-rigorous, peer-reviewed studies does not currently exist on this emerging technology; manufacturer data should be carefully considered. Must comply with UL 2996 and AHSRAE 62.1 as ozone build up can be harmful.

• Hypochlorous Acid
  • May reduce cleaning time. Electrostatic sprayer including backpack style.
Emergency Department


• Evaluate Air System Operation and Alternative Measures
  – Example: Convert Open Bay or Trauma Room with Use of HEPA Recirculation Unit to Multiple Patient Station
  – Example: Convert AHU Temporarily to Once Through Air System; Supplement Make Up Air Needs with Temporary A/C As Needed
  – Have a Contingency / Fall-Back Plan
Layered Approach: A Variety of Options

New CDC/NIOSH Info on “Expedient Patient Isolation Rooms”

See overview of options 1-6, plus links below to detailed information on these, plus Options 7 & 8. Evaluate what works best for your condition(s).

• Normal Operations – Option 1
  – Follow CDC, ASHRAE, FGI Guidelines per your local code.
  – Clinical plan may limit airborne infection isolation room use to aerosol generating procedures.

• Small Surge Option 2
• Small Surge Option 3
• Small Surge Option 4
• Small Surge Option 5
• Small Surge Option 6 – see image ➔
• Small Surge Option 7 (HEPA Unit to return with protective tent)
• Small Surge Option 8 (HEPA filter @ each return grille)
Small Surge: Option 2 Direct to Outside

- Single patient room with dedicated bathroom
- Seal off return air grill in patient room
- Duct through exterior to the outside.
- Remove window and enclose opening
- Keep door to patient room closed
- Verify negative pressure prior to placing room in service and monitor negative pressure while in service
- Limit patient transport and patient transfers
- Terminal cleaning after ACH removes potentially infections particles
- Notify Healthcare workers that HEPA units can not be turned off once in place as this may result in an unsafe condition with the room becoming positively pressurized to the corridor.

The most preferred recommendation is to co-locate all patients to an area served by a single air handling unit and to modify that unit to create negative pressure for the entire area being served. If it is possible the filters on this system should be replaced with HEPA filters. Prior to placing the unit into service the negative pressure of the area should be verified and it should be monitored throughout the time COVID-19 patients are treated within the area.
Small Surge: Option 3 HEPA to Outside

- Single patient room with dedicated bathroom
- Seal off return air grill in patient room
- Place HEPA filtered negative air machine in patient room
- Duct through HEPA and then through exterior to the outside.
- Remove window and enclose opening
- Keep door to patient room closed
- Verify negative pressure prior to placing room in service and monitor negative pressure while in service
- Limit patient transport and patient transfers
- Terminal cleaning after ACH removes potentially infectious particles
- Notify Healthcare workers that HEPA units can not be turned off once in place as this may result in an unsafe condition with the room becoming positively pressurized to the corridor.

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Small Surge: Option 4 – HEPA to Return

- Single patient room with dedicated bathroom
- Place HEPA filtered negative air machine in patient room
- Duct to return air grill
- Seal off remaining part of return air grill
- Verify impact that this will have to the overall air handling system – choosing rooms closest to the air handler may reduce impact
- Keep door to patient room closed
- Verify negative pressure prior to placing room in service and monitor negative pressure while in service
- Limit patient transport and patient transfers
- Terminal cleaning after ACH removes potentially infections particles
- Notify Healthcare workers that HEPA units can not be turned off once in place as this may result in an unsafe condition with the room becoming positively pressurized to the corridor.

The most preferred recommendation is to co-locate all patients to an area served by a single air handling unit and to modify that unit to create negative pressure for the entire area being served. If it is possible the filters on this system should be replaced with HEPA filters. Prior to placing the unit into service the negative pressure of the area should be verified and it should be monitored throughout the time COVID-19 patients are treated within the area.
Small Surge: Option 5 – HEPA to Corridor

- Single patient room with dedicated bathroom
- Create “airtight” vestibule to patient room
- Need minimum 5’-0” egress clearance in the corridor
- Seal off return air grill in patient room
- Place HEPA filtered negative air machine in vestibule
- Duct through vestibule to corridor
- Keep door to vestibule closed but door to patient room open
- Verify that patient room door is not a rated fire door!
- Verify negative pressure prior to placing room in service and monitor negative pressure while in service
- Limit patient transport and patient transfers
- Terminal cleaning after ACH removes potentially infectious particles
- Notify Healthcare workers that HEPA units can not be turned off once in place as this may result in an unsafe condition with the room becoming positively pressurized to the corridor.
Small Surge: **Option 7 – HEPA to Return with Protective Tent**

- Single patient room with dedicated bathroom
- Place HEPA filtered negative air machine in patient room
- Install protective portable isolation tent around bed.
- Duct from tent into HEPA and from HEPA into return air grill
- Seal off remaining part of return air grill
- Verify impact that this will have to the overall air handling system – choosing rooms closest to the air handler may reduce impact
- Keep door to patient room closed
- Verify negative pressure prior to placing room in service and monitor negative pressure while in service
- Limit patient transport and patient transfers
- Terminal cleaning after ACH removes potentially infections particles
- Notify Healthcare workers that HEPA units can not be turned off once in place as this may result in an unsafe condition with the room becoming positively pressurized to the corridor
Small Surge: Option 8 – HEPA filter on each return grille, reduce supply to keep room negative to corridor

- Single patient room with dedicated bathroom
- Place HEPA filters at each return grille in the room
- Seal off remaining part of return air grill
- Reduce supply air until room is negative to the corridor.
- Verify impact that this will have to the overall air handling system – choosing rooms closest to the air handler may reduce impact
- Keep door to patient room closed
- Verify negative pressure prior to placing room in service and monitor negative pressure while in service
- Limit patient transport and patient transfers
- Terminal cleaning after ACH removes potentially infections particles
- Notify Healthcare workers that HEPA units can not be turned off once in place as this may result in an unsafe condition with the room becoming positively pressurized to the corridor
Source Control Options

Consider Local Exhaust Source Control at Patient Head for Patients on CPAP, Nebulizer, or other AGP.

- Patient Tent w HEPA (ie Demistifier)
- Portable Snorkel Exhaust (ex. units used for soldering)
Source Control Options

Ventilated Headboard (can be custom built on site)

- New video from CDC/NIOSH of construction and research validation of ventilated headboard.

Figure 18. Schematic of ventilated headboard single-patient configuration evaluated at the VA Medical Center in Oklahoma City.

Figure 19. Photograph of ventilated headboard and hood frame as constructed for research at the Oklahoma City VA Medical Center.
Operating on a COVID-19 Patient

• Avoid Use for COVID Patients IF YOU CAN

• **Additional Info**

• If you must:
  • Recommend Intubation in Airborne Infection Isolation Room, or if AIIR not available then in Operating Room
  • Use Negative Pressure Operating Room if you have
  • Recommend Creating [Temporary Vestibule](#) in lieu of Creating a Negative Pressure OR
    − Creates Buffer Zone of Negative Pressure, but maintains OR cleanliness
  • Recommend Dedicating an Operating Room for COVID use only
Operating on COVID-19 Patient

Additional Resources:

• Intubation Guard
  - Built device
  - Staff protection
  - Use and remove
  - Cleanable
  - May restrict needed movement
  - Seek clinician input first

• Further Guidance
  - Operating Room
  - Handbook of Care
Variable Air Volume Systems

• Recognize that VAV Systems Will Vary Airflow Quantity, which presents a risk to maintaining clean to less clean airflow.
  • Varying Air Flow Will Hamper Air Balance Goals of COVID Area

• If housing COVID Patients in Area Served by VAV System:
  • Recommend Resetting Minimum Airflow Setting to Match Maximum
  • Fixed Air Changes Will Permit Stable Air Balance of COVID Area
  • May Result in Increased Cooling, Reheat Consumption
  • Typical AHU with Economizer – converting to once through system
  • Typical AHU without Economizer – converting to once through system
Typical Air Handler w/ Airside Economizer

HVAC – Once through system:

**Considerations**

- Increase Bathroom Exhaust Airflow to Create Room Negative Pressure
- Supply Air to Patient Rooms
- Return Air from Patient Rooms
- Relief Air from Patient Rooms
- Block Off (or HEPA)
Considerations

Optional, not required: May want to consider increase of bathroom exhaust airflow.

This becomes **Temporary Exhaust** from patient rooms. Consider location of this exhaust in relation to outside air intakes to avoid re-entrainment. Provide temporary signage and means to prevent people from going near the exhaust termination location.
Room Recirculating Units

There are a variety of in-room recirculating units that utilize decoupled cooling/heating coils:

- Units with moderate filtration due to wetted coil
  - Fan Coil Units
  - Heat Pump Units
  - Package Terminal Air Conditioner (PTAC)
  - DX and Mini-Split DX Units
- Units with no filtration requirement (sensible coil)
  - Induction Units
  - Active Chilled Beams
- The recirculation aspect allows these units to operate at $\leq 6$ ACH

Cautions for rooms with recirculating units
Caution – Room Recirculating Units

Avoid use for COVID patients if possible, but if you must:

• Consider [Option 7](#) as best layout approach
• If no other option, increase room exhaust
  – Create negative pressure relative to corridor
  – May be accomplished with localized exhaust fan in each room
  – Consider system level approach by utilizing increase general or toilet exhaust airflow
  – Consider means of sanitizing RR units between patients
  – Deep decontamination of RR unit coil after event is over
2-Person Patient Rooms

See How-To Document for guidance on creating or managing existing 2-patient rooms.

- **Expedient Patient Isolation Rooms How To**
- Consider fire sprinkler coverage considering isolation curtains
- Inner patient zones should not include recirculating HVAC wall units or HVAC return air grilles unless they can be sealed tight.
Cautions when using OR as Temporary ICU

Operating Room (OR) as COVID-19 Patient Room/Temporary ICU

- Why? Offers a large space for multiple patients with access to O₂, Anesthesia & ventilator machines
- Avoid using OR if possible, but if you must:
  - Consider dedicating an OR to COVID patients only or segregate area from remainder of OR suite
  - Recommend intubation in OR
  - Recommend controlled air vestibule in lieu of creating a holistic negative pressure OR, thus creating a buffer zone of negative pressure while maintaining OR cleanliness
  - Reduce air changes to 6-12 total ACH
  - Modify OA balance to match total/exhaust air.
  - Modify capacity for cooling/dehumidification
  - All air exhausted from space or HEPA filtered and ducted to return. Label old relief air opening as contaminated exhaust and confirm it will not be re-entrained into OA intakes.
Temporary Vestibule at OR

• Example of temporary vestibule to create a negative pressure zone separating OR from corridor
• HEPA unit in vestibule creates negative pressure relationship
• Seal other entries to OR to mitigate any contamination potential
Warning on Older ICU Units

Intensive Care Unit (ICU) Rooms

• May operate under positive pressure – verify and address
  − Must operate under negative pressure
  − Designate specific room(s) and area(s)
  − Proactively review and modify test and balance as needed
  − Consider system level, once air approach is determined
  − Changing OA volume may impact building pressure balance
  − Monitor humidity effects due to system changes
  − All air exhausted from space or HEPA filtered and ducted to return
Gastrointestinal Endoscopy

Suggested Approach for Endoscopy Procedures

• ASHRAE Standard 170 requires 6 total ACH for Gastrointestinal Endoscopy procedure rooms. There is no pressure requirement. Airflow may not be recirculated within the room.

• Be aware that pressure relationships for Endoscopy rooms have changed over the years. Re-confirm facility operating condition.

• Test patients for COVID-19. Patients who test positive should have their procedure delayed until following recovery, if possible.

• If the procedure is an aerosol generating procedure, regardless of whether it is on a COVID-19 positive patient or not, perform the procedure in an airborne infection isolation room or a bronchoscopy room.

• ASHRAE Standard 170 requires 12 total ACH for Bronchoscopy rooms. The room must be negative, 100% exhaust, and no recirculation within the room.

• If the procedure is not aerosol generating, patient is COVID-19 positive or unknown and procedure can not be delayed then recommend these options, in order
  – Perform procedure in airborne infection isolation room or a bronchoscopy room.
  – Modify existing endoscopy room to provide containment and protection for staff. This includes 100% exhaust with HEPA filtration or HEPA filtered return. Consider a HEPA filtered vestibule. See links to Layered Approach and Variable Air Volume Systems for concepts on converting to 100% exhaust and for HEPA filtered return.
  – Perform procedure in Operating Room for COVID-19 patient.
Transmission through air in toilet rooms

Studies have shown that toilets can be a risk of generating droplets and droplet residues from plumes in the air that could contribute to transmission of pathogens.

- Keep toilet room doors closed, even when not in use
- Put the toilet seat lid down, if there is one, before flushing

December 2018 – American Journal of Infection Control.
- C-Diff seeded in a toilet
- Water samples, settle plates, and air samples
- Spores present after 24 flushes
- Droplet nuclei spore bioaerosol produced over at least 12 flushes

Gas/Vac Systems

Demand for Gasses in ICU Rooms

• Oxygen (O2)
  – Typically fitted out with three (3) outlets for a total flow of about 1.0 scfm plus ventilator demand
  – Ventilators deliver gas to a patient based on their respiration rate and their lung capacity
  – Ventilators can consume 100% MS-AIR (w/ 21% oxygen) and no O2 all the way up to 0% MS-AIR and 100% O2 depending on the ability of lungs to exchange gasses in the blood
  – Gross O2 demand adds up to a range of 2.0-2.5 scfm

• Medical-surgical compressed air (MS-AIR)
  – Typically fitted out with one (1) outlet for a total flow of about 1.0 scfm plus ventilator demand
  – Gross MS-AIR demand adds up to a range of 2.0-3.0 scfm

• Ventilators
  – Multiple patients serviced by a common ventilator is not recommended by medical officials for a variety of reasons
Gas/Vac Systems continued:

Demand for Gasses in Med-Surg Rooms and ORs

• Medical-surgical patient rooms
  − These rooms have insufficient # of O2 and MS-AIR outlets, but their local piping connections may be sufficient to handle ventilators for certain clinical cases; they’d be sufficient for those patients who need O2, but don’t need a ventilator to breathe for them.

• Operating rooms
  − ORs become options because they are fitted out with O2 and MS-AIR in sufficient capacity to allow the use of anesthesia machines as ventilators (the ASA has guidance).
  − Using an OR as an Airborne Infection Isolation room creates a problem with the area alarms because of the location of the pressure sensor. Consider “fire watch” type monitoring of zone valve boxes.
  − Using an OR temporarily as an Airborne Infection Isolation room will require that pressurization be addressed including ante-rooms and exhaust for the room itself (could use a dedicated smoke exhaust if the suite is fitted out with such a system).
Gas/Vac Systems continued:

Accommodating increased demand (flow) in fixed piping systems

• Raising system pressure in O2 systems
  – Raise pressure up to 55 psig if not set there already
  – Supplier may need to do this because the regulator is within the bulk plant enclosure
  – Can be done by facility staff at manifol ded sources
  – Re-calibrate area alarm panels

• Raising system pressure in MS-AIR systems
  – Rise pressure up to 55 psig if not set there already
  – Can be done by facility staff at compressor sets or manifol ded sources
  – Re-calibrate area alarm panels

• Reducing pressure drop through the piping
  – Provide temp O2 and/or MS-AIR sources near ICU suite
  – Provide temp ICU rooms closer to existing sources
Gas/Vac Systems Continued:

Impact of demand/consumption on existing gas systems

• O2 systems
  – More rapid and increased O2 consumption leads to more ice buildup on vaporizer; de-icing service critical. Consider use of portable fans or misters to reduce ice build-up on vaporizers.
  – Ensure bulk supplier can make more frequent deliveries
  – Ensure supplier can make more cylinder/container exchanges
  – Test your LPEOSC to ensure that it’s in working order
  – Consider using your LPEOSC as a means by which more product can be introduced into the existing piping

• MS-AIR systems
  – Increased demand and consumption may result in standby compressors operating; consider adding another receiver as a buffer
  – Longer run times could result in compressors and/or motors overheating; consider better ventilation of equipment room or spot cooling
  – Ensure supplier can make more cylinder/container exchanges
Gas/Vac Systems Continued:

Consider providing supplementary gas sources

- Provide auxiliary source connection at bulk plants per NFPA 99 (new requirement in the 2015 edition)
  - Mitigates the use of the LPEOSC as more than just a short-term, interim source

- Provide additional LPEOSC
  - Strategically located in case the other LPEOSC is obstructed for some reason; interconnection critical

- Provide in building emergency reserve (IBER) as defined by NFPA
  - This can be manifolded sources of high pressure gas (cylinders) or high pressure liquids (containers) for O2 and/or MS-AIR
  - Ensure that new storage rooms have enough space, have product secured safely and are properly ventilated properly

- Provide redundant vacuum and compressor sets
  - Careful interconnection required