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ENHANCED RESPIRATORY ISOLATION

Background: SARS-CoV-2, the virus that causes the disease COVID-19, is spread from person to person, mainly through respiratory droplets. These droplets can land in the mouth or nose of people who are nearby or possibly be inhaled into the lungs. Spread is more likely when people are in close contact with one another (within 3-6 feet).

It is also possible that transmission can occur by touching a surface or object that has the virus on it and then touching mouth, nose, or eyes, although this route likely accounts for a minority of transmissions.

Policy: This policy provides requirements for Enhanced Respiratory Isolation (ERI) in the setting of the COVID-19 pandemic. This policy will be updated as appropriate. ERI is intended to protect healthcare workers from potential exposure to SARS-CoV-2 and prevent transmission from patient to patient.

Patients Requiring Enhanced Respiratory Isolation (ERI):

1. Patients with a suspected viral respiratory illness. This category includes all patients with any of the following signs or symptoms:
   a. Fever, subjective or documented
   b. New sore throat
   c. New cough
   d. New runny nose or nasal congestion
   e. New muscle aches
   f. New shortness of breath
   g. New anosmia/ageusia

2. Patients identified as COVID-19/CoV- Presumed, CoV-Risk, or CoV-Exposed
   a. Patients are identified by their infection status in Epic.
   b. Infection statuses are activated by orders for COVID-19 testing, positive test results, or may be entered by staff.
   c. See Partners Policy on COVID-19 Infection Statuses and Resolution for definitions of each infection status.

3. Note that this policy does NOT apply if a patient with signs and symptoms of a respiratory viral illness is ruled out for COVID-19 (i.e. meets Partners and site criteria for removal of all COVID-related infection status flags). See local Infection Control Policy related to other respiratory viruses (e.g., influenza, RSV, etc.).

Enhanced Respiratory Isolation (ERI) – Inpatient locations
ERI is a new isolation category; requirements are as follows:

1. Patient placement:
   a. Private room with the door closed; cohorting of confirmed COVID-19 patients is permitted so long as there are no other infection status mismatches (e.g. MRSA, C. difficile, etc.). Cohorting is not permitted for CoV-Presumed, CoV-Risk, CoV-

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Exposed. Placement in an Airborne Infection Isolation Room (AIIR) is strongly preferred if AGPs are anticipated.

b. AIIRs should be prioritized for patients with the highest likelihood of COVID-19 who require AGPs when there is a shortage of AIIRs. Prioritization of AIIRs in these situations is based on patient risk of COVID-19 infection as follows:
   i. 1st priority: COVID-19/CoV-Preumed
   ii. 2nd priority: CoV-Risk
   iii. 3rd priority: CoV-Exposed
   iv. 4th priority: Other viral respiratory illness

c. Tuberculosis, varicella, and measles patients require an AIIR and are not included in this guidance. Consult with Infection Control regarding patient placement for these infections.

d. Immunocompromised COVID-19, CoV-Preumed, CoV-Risk, and CoV-Exposed patients who meet criteria for requiring a Protected Environment (PE) rooms (positive pressure).
   i. Place in a combination Airborne Infection Isolation/Protected Environment rooms (AIIR/PE room) if available.
   ii. If an AIIR/PE room is not available, a decision must be made as to the necessity for a Protected Environment room relative to the level of immunocompromise and risk for fungal infection.
   iii. Consult local Infection Control for institution specific guidance. The following are general guidance:
      1. Patients at high-risk for fungal infection for whom there is no plan or risk for AGPs may be placed in a PE (positive pressure) room.
      2. Patients at high-risk for fungal infections who will likely have an AGP should be placed in a standard room.
      3. Patients who are not at high-risk for fungal infection should be placed in a standard room.

2. AGP Procedures:
   a. See Infection Control Guidelines for Aerosol-Generating procedures for list of AGPs and detailed guidance on risk mitigation strategies for performing AGPs in AIIRs vs. a standard patient room.

3. Nasopharyngeal (NP) Swab collection: NP swabbing is not considered an aerosol-generating procedure; negative pressure room not required
   a. Minimize staff in the room; single provider preferred.
   b. Ensure the is door closed.
   c. Staff in the room must wear required ERI PPE (listed below).
   d. If patient is cohort in a 2-bed room, close the curtain and ensure the other patient is wearing a surgical mask.
   e. Disinfect all high-touch surfaces immediately after the procedure.

4. Personal Protective Equipment (PPE):
a. The following PPE is required for all staff upon entry to patient room: gown, gloves, eye protection, and N95 respirator or powered air-purifying respirator (PAPR) if staff cannot be fit-tested.

b. Gown, gloves, and eye protection are donned upon exiting either just inside or just outside the door, and hand hygiene is performed.

c. Respiratory protection should be removed after exiting room unless extended use is being practiced.

d. Respiratory and eye protection may continue to be worn per Partners Extended Use and Reuse of PPE Policy.

5. Post-discharge cleaning (see cleaning section at end of document for more detail)

Enhanced Respiratory Isolation – Outpatient Locations (i.e. Ambulatory Care, Imaging, Emergency Department)

1. Patient placement:
   a. Patient is masked on arrival and should remained masked for duration of visit.
   b. If not possible to room immediately, keep patients at least 6 feet apart, with physical barriers between patients if possible.
   c. Preferably place patient in a single exam room with the door closed.
   d. Outpatient locations with examination bays with curtains should work with Infection Control on a plan for how appropriate distancing between patients will be managed. At a minimum, curtains should be closed.
   e. Placement in an Airborne Infection Isolation Room (AIIR) or other negative pressure environment (e.g., Oasis pod) is preferred if AGPs are anticipated.
   f. AIIRs should be prioritized when there is a shortage of AIIR rooms and there is a need for AGPs. Prioritization of AIIRs in these situations is based on patient risk of COVID-19 infection as follows:
      i. 1st priority: COVID-19/CoV-Exposed
      ii. 2nd priority: CoV-Risk
      iii. 3rd priority: CoV-Exposed
      iv. 4th priority: Other viral respiratory illness
   g. Tuberculosis, varicella, and measles patients require an AIIR and are not included in this guidance. Consult with Infection Control regarding patient placement for these infections.

2. AGP Procedures:
   a. See Infection Control Guidelines for Aerosol-Generating procedures for list of AGPs and detailed guidance on risk mitigation strategies for performing AGPs.

3. Nasopharyngeal (NP) Swab collection: NP swabbing is not considered an aerosol-generating procedure; negative pressure room not required
   a. Collection of NP swab is preferentially done in a room with a door, if available. If only curtained bays, close curtain.
   b. Minimize staff in the room/area; single provider preferred.
   c. Ensure door/curtain is closed.

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d. Staff in the room must wear required ERI PPE (listed below).

e. Disinfect all high-touch surfaces immediately after the procedure.

4. Personal Protective Equipment (PPE):
   a. The following PPE is required upon entry to exam room/bay: gown, gloves, eye protection, and N95 respirator or powered air-purifying respirator (PAPR) if staff cannot be fit-tested.
   b. Gown, gloves, and eye protections is doffed upon exiting either just inside or just outside the door/curtain and hand hygiene performed.
   c. Respiratory protection should be removed after exiting room and closing door unless extended use is being practiced.
   d. Respirator and eye protection may continue to be worn per Partners Extended Use and Reuse of PPE Policy.

5. Post-encounter cleaning (see cleaning section at end of document for more detail)

Enhanced Respiratory Isolation (ERI) – Procedural Areas (i.e. Operating Room, Cath Lab, EP Lab, Interventional Radiology, Endoscopy)

1. Patient placement:
   a. Patient is masked on arrival.
   b. Patient is roomed immediately. Room with a door is preferred.
   c. Procedural areas that have bays with curtains should work with Infection Control on a plan for how these patients will be managed. At a minimum, curtains should be closed.

2. Personal Protective Equipment (PPE):
   a. The following PPE is required for staff providing direct patient care: gown, gloves, eye protection, and N95 respirator or powered air-purifying respirator (PAPR) if staff cannot be fit-tested.
   b. PPE is doffed and hand hygiene is performed when exiting patient care environment and entering other common spaces.
   c. Respirator and eye protection may continue to be worn per Partners Extended Use and Reuse of PPE Policy.

3. AGP Procedures in Operating Rooms (ORs) and Procedure Rooms: Operating rooms and procedure rooms are designed to be positive pressure and have a high number of air changes per hour (ACH). These engineering controls are intended as measures to decrease risk of infection associated with invasive procedures. Therefore, changing airflow direction in these rooms is not recommended. This high number of air changes per hour removes particulates in the air at a high rate. The following: mitigation measures are required for patients undergoing AGPs in these areas.
   a. Staff in the room during the AGP should be limited to essential staff only.
   b. Staff who will have direct contact with the patient (both intubation and extubation) will wear PPE per ERI requirements (e.g., gown, gloves, N95 or PAPR and eye protection).
   c. Some locations may implement the use of a negative pressure hood during intubation and extubation as an additional source control measure. Use of
these devices does not change requirements for ERI PPE or required airing time.

d. After AGP is completed and after airing time, circulator or other staff in the room, not having direct contact with patient, can doff gown and gloves and perform hand hygiene. After performing hand hygiene, they may enter supply cabinets as needed. If circulator or other staff need to access clean supplies before airing time has completed, they may remove gloves and perform hand hygiene and don clean gloves to access supplies.

e. After extubation or other AGPs, allow for appropriate air exchanges (30 minutes for ORs and Procedure Rooms). Requests for shorter airing times based on higher numbers of air exchanges can be directed to local Infection Control. If your site is not listed, use 30 minutes.
   • Cooley Dickinson Hospital: click here.

f. Anyone entering the room during the airing time must wear PPE per ERI requirements (e.g., gown, gloves, eye protection, and N95 respirator or powered air-purifying respirator (PAPR) if staff cannot be fit-tested).

g. Standard room turnover cleaning and disinfection must occur with a focus on high-touch surfaces around the patient bed/stretcher area. To minimize amount of equipment to be cleaned, if possible, move unnecessary equipment away from the bed or stretcher during the AGP.

h. Room may be cleaned by staff wearing PPE per ERI requirements during the airing time (e.g., gown, gloves, N95 respirator or powered air-purifying respirator (PAPR) if staff cannot be fit-tested).

i. Staff may enter the room without PPE after airing time and room cleaning have been completed.

**AGPs in Asymptomatic Patients not on Enhanced Respiratory Isolation**

1. Asymptomatic patients admitted to Partners Acute Care facilities are tested for COVID-19 within 72 hours prior to admission or on admission. Patients who are asymptomatic and have a negative COVID-19 test will be on Standard Precautions for AGPs during their admission.

2. Asymptomatic outpatients with planned or anticipated ambulatory AGPs should be referred for testing for COVID-19 within 72 hours prior to the planned AGP. Patients who are asymptomatic and have a negative COVID-19 test and who are on Standard Precautions will be on Standard Precautions for AGPs during their admission.

3. ERI precautions will be followed for patients who have unknown COVID-19 status who are undergoing a Partners defined AGP for the duration of the procedure and for the required room airing time post procedure. Patients who are otherwise on Standard Precautions or other isolation precautions (i.e. Contact Isolation for MDROs) will return to their prior status following the AGP.

Signage indicating when airing time will be completed is required to be posted after an AGP for a patient who will be returning to Standard Precautions to alert staff to the need for ERI PPE during the airing time.
Patient Care Equipment/Supplies
1. Equipment (e.g., stethoscope, blood pressure cuff, thermometers) should be single-use or dedicated to use of the patient to avoid sharing with other patients. Reusable patient care equipment must be disinfected with a hospital-approved disinfectant before use for another patient.
2. Supplies in the room of a patient on Enhanced Respiratory Isolation or the exam room where a patient on Enhanced Respiratory Isolation is being evaluated should be kept to a minimum.
3. Disposable items (e.g., adhesive tape, gauze etc.) must be discarded on discharge in inpatient location. In ambulatory locations, supplies touched without removal of gloves and hand hygiene performed must be discarded.

Cleaning
1. There are no special cleaning and disinfection procedures required for patients on Enhanced Respiratory Isolation. Standard hospital-approved disinfectant products are effective against SARS-CoV-2.
2. Standard cleaning procedures must be followed consistently and correctly.
3. Daily cleaning and disinfection of inpatient rooms should include high-touch surfaces.
4. Cleaning and disinfection of exam or procedure rooms between patients in outpatient and diagnostic locations should include equipment and high-touch surfaces.
   a. Outpatient and diagnostic locations must have clear protocols for which specified role groups will perform cleaning and disinfections of rooms and equipment and PPE requirements.
5. Cleaning staff will wear ERI PPE during daily inpatient room cleaning. Cleaning staff, wearing ERI PPE, may enter a room to clean during the airing time after an AGP.
6. Discharge Cleaning
   a. There is no routine airing time required post discharge unless the patient had an AGP just prior to discharge.
   b. Cleaning staff, wearing ERI PPE, may enter the room for discharge cleaning during the airing time after an AGP.
   c. ERI signage should remain on the door until discharge cleaning has been completed.
7. Cleaning after discontinuation of isolation.
   a. COVID-19/CoV-Presumed infection status may be resolved while the patient is hospitalized per Partners Infection Status Resolution criteria.
   b. When COVID-19/CoV-Presumed infection status is resolved, the patient should be moved to a clean room and discharge cleaning completed.
      i. If patient cannot be moved, a thorough daily clean should be completed, and supplies in the rooms should be discarded
      c. If patient is in a semi-private room and will remain in that room the patient should be moved to the clean bed in the room, a discharge clean of the entire

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Transport of Patients on Enhanced Respiratory Isolation - Inpatients

1. Limit patient transport or movement to essential purposes only.
2. Notify the receiving department regarding patient Infection or Isolation Status prior to transport to department.
3. If transport or movement outside of the patient room is necessary:
   a. Place a face-mask (surgical or procedural mask) on the patient
   b. If the patient is intubated, place a bacterial filter on the endotracheal tube or on the expiratory side of the breathing circuit of a ventilator or anesthesia machine.
   c. If the patient is not intubated but requires supplemental oxygen, avoid high-flow nasal cannula or non-invasive ventilation due to aerosolization risk. Preferentially use low-flow oxygen, Venturi masks, or non-rebreather masks.
   d. If the patient has a tracheostomy, a mask may be placed over it and over the patient’s nose and mouth.
   e. Wounds must be covered, and body fluids contained.
   f. The patient should wash or disinfect his or her hands before leaving the room if possible.
   g. The patient should wear a clean johnny or robe or be covered by a clean sheet or drape for transport to another department or area.
4. Staff Personal Protective Equipment (PPE) During Transport:
   a. Gown, gloves, and eye protection should not routinely be worn by staff when transporting patients on a clean stretcher or wheelchair. A surgical mask is worn per Universal Mask Policy. Exceptions to this are detailed below.
   b. All staff involved should wear ERI PPE in the patient room while preparing the patient for transport.
   c. The patient should preferably be brought out of his/her room by local clinical staff and transferred to a clean bed, stretcher or wheelchair outside the room in order to save patient transport personnel from having to enter the room and to avoid moving a contaminated bed or wheelchair through the hospital.
   d. Transporting Patients in Beds/Stretchers that have been in the patient room and/or patients that require direct patient care during transport:
      i. Staff should wear face-mask (surgical or procedural mask) per Universal Mask Policy, or N95 per extended use or reuse. Exception: ERI PPE (gown, gloves, eye protection, and N95 respirator or powered air-purifying respirator (PAPR) if staff cannot be fit-tested.) must be worn when direct contact with the patient and/or contact with contaminated equipment will occur during transport.
ii. If staff members who were previously in the patient room will be assisting in transport and anticipate direct contact with the patient and/or contact with contaminated equipment during transport, they can wear the same PPE, but must not touch any surfaces outside the room during transport.

iii. When patients are transported in a bed that the patient has already occupied (i.e., hospital bed going to and from the OR), staff will wipe down bed frame, rails, and handles with a hospital-approved disinfectant immediately prior to transport.

iv. There must be a member of the transport team, not wearing PPE (other than a face-mask as per universal mask policy or N-95 respirator per Partners Infection Control Guidance for Patients with Suspected Viral Respiratory Illness), who has clean, non-gloved hands to interact with the environment (e.g., pressing elevator buttons).

v. Staff will doff PPE when contact with patient and/or contaminated equipment is completed.

e. Transporting Patients in a Clean Wheelchair or on a Clean Stretcher:

i. The patient should preferably be brought out of their room by local clinical staff and transferred to a clean wheelchair/stretcher outside the room in order to save patient transport personnel from having to enter the room and to avoid moving a contaminated wheelchair through the hospital.

ii. The patient should wash or disinfect his or her hands before leaving the room if possible.

iii. The patient should wear a surgical or procedural mask, a clean johnny or robe or be covered by a clean sheet or drape for transport to another department or area.

**Transport of Patients on Enhanced Respiratory Isolation - Ambulatory Care**

1. **Gown, gloves, and eye protection should not routinely be worn by staff when transporting patients. A surgical mask is worn per Universal Mask Policy.**

2. Patients should be masked per Universal Mask Policy.

3. For patients who require direct patient care during transport, see inpatient transport requirements.

**Transport by Elevator**

1. The elevator can be immediately reused, and no cleaning is required after use for transporting a patient with suspected or confirmed COVID-19. Staff transporting the patient will ensure the following:
   a. The patient does not touch surfaces within the elevator, and
   b. Only transport team members with clean, non-gloved hands pressed the elevator buttons (staff wearing PPE should not press elevator buttons).

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Other Transport Considerations

1. Facilities may choose to identify a role for Police and Security to escort patients during movement in order to ensure paths are cleared and no other patients or staff come close to the patient or enter the same elevator.

2. Examples:
   a. Patient with suspected or confirmed COVID-19 with scheduled appointment or admission requiring escort to appointment
   b. Patient going to and from procedures or the Operating Room
   c. Confirmed COVID-19 patient being discharged
   d. Escort of acutely ill patient from the heliport

3. In these cases, Police and Security will wear a face-mask (surgical or procedural mask) per Universal Mask Policy or N95 as per extended use or reuse policy per Partners Infection Control Guidance for Patients with Suspected Viral Respiratory Illness and maintain a distance of 6 feet from the patient. They will have clean, non-gloved hands to press elevator buttons and open doors and will not interact directly with the patient, wheelchair/stretcher/bed, or equipment.