


Letter to the Editor

A safe and efficient, naturally ventilated structure for COVID-19 surge capacity in Singapore

Natasha Bagdasarian MD, MPH^{1,2} , Ian Mathews MBBS, MCEM, MMed³, Alexander J. Y. Ng MBBS³, Eugene H. Liu MD, MPhil, FRCA^{2,4}, Clara Sin MBA⁵, Malcolm Mahadevan MBBS, FRCP, FRCS³ and Dale A. Fisher MBBS, FRACP^{1,2}

¹Division of Infectious Diseases, Department of Medicine, National University Hospital, National University Health System, Singapore, Singapore, ²Department of Medicine, Yong Loo Lin School of Medicine, National University of Singapore, Singapore, Singapore, ³Emergency Medicine Department, National University Hospital, National University Health System, Singapore, Singapore, ⁴Department of Anesthesia, National University Hospital, National University Health System, Singapore, Singapore and ⁵Hospital Operations, National University Hospital, National University Health System, Singapore, Singapore

To the Editor—The need for airborne infectious isolation (AII) surge capacity is a problem for hospitals globally,^{1,2} and this problem has been highlighted during the COVID-19 pandemic.³ Alternatives to AII rooms have been proposed for surge periods. Airborne isolation units can be quickly converted to cohort patients with the same illness, typically requiring negative pressure relative to adjacent areas and adequate ventilation without recirculation to other areas.^{2,4} Mobile containment units have been used in conflict zones⁵ and in outbreak response settings^{6,7} including the current pandemic. Many countries still face spiraling numbers of cases, while others are attempting to return to normalcy after a period of lockdown; some of these countries may experience a second wave even larger than the first. Here, we describe the design and function of a low-cost, naturally ventilated temporary structure to increase EMD capacity during the COVID-19 response in Singapore.

National University Hospital (NUH) is a 1,200-bed tertiary-care academic hospital in Singapore, with an emergency medicine department (EMD) that sees more than 110,000 patients per year. With the emergence of COVID-19, containment strategies were implemented nationally, requiring isolation of large numbers of patients and placing an extraordinary demand on the existing healthcare infrastructure. A multidisciplinary taskforce was assembled to plan for surge capacity, with the intent to create an “EMD extension,” a temporary outdoor facility to manage patients with suspected COVID-19 and relieve the pressure on the existing EMD isolation facilities.

We designed an A-shaped structure with open-air sides and a canvas roof, a perimeter fence for privacy, and ceiling fans to maximize air flow. The structure measured 31 m × 16.5 m, with a height of 5 m at its highest point (Fig. 1). This temporary structure was built on an existing empty flat concrete platform, which was covered with vinyl flooring. The structure contained a resuscitation bay and a radiology cubicle with walls lined with lead shields; an adjacent air-conditioned cabin served as a rest area for staff.

Author for correspondence: Natasha Bagdasarian, E-mail: natasha_bagdasarian@nuhs.edu.sg

Cite this article: Bagdasarian N, et al. (2021). A safe and efficient, naturally ventilated structure for COVID-19 surge capacity in Singapore. *Infection Control & Hospital Epidemiology*, 42: 630–632, <https://doi.org/10.1017/ice.2020.309>

The structure has 20 patient cubicles (2 m × 2 m), constructed using aluminum framing and polyvinyl chloride (PVC) panels. The walls are 2.5 m high, with 3 fixed and 1 curtained side. The modular nature of the construction allowed for 5 additional cubicles to be added later.

Alcohol-based hand rub (ABHR) dispensers were placed in patient cubicles, at healthcare worker (HCW) stations, at medication preparation station, and in the donning and doffing areas. Hand hygiene sinks were installed and connected to the main water supply line, and portable toilets were connected to central sewage.

We engaged a local tent contractor without specific expertise in medical or emergency response structures, although the designs were verified with an engineer. The structure was erected within 17 hours, followed by fire safety checks, temperature monitoring, rehearsals of patient movement and resuscitation drills, and a smoke test that demonstrated good air flow. The structure was fully operational within 6 days.

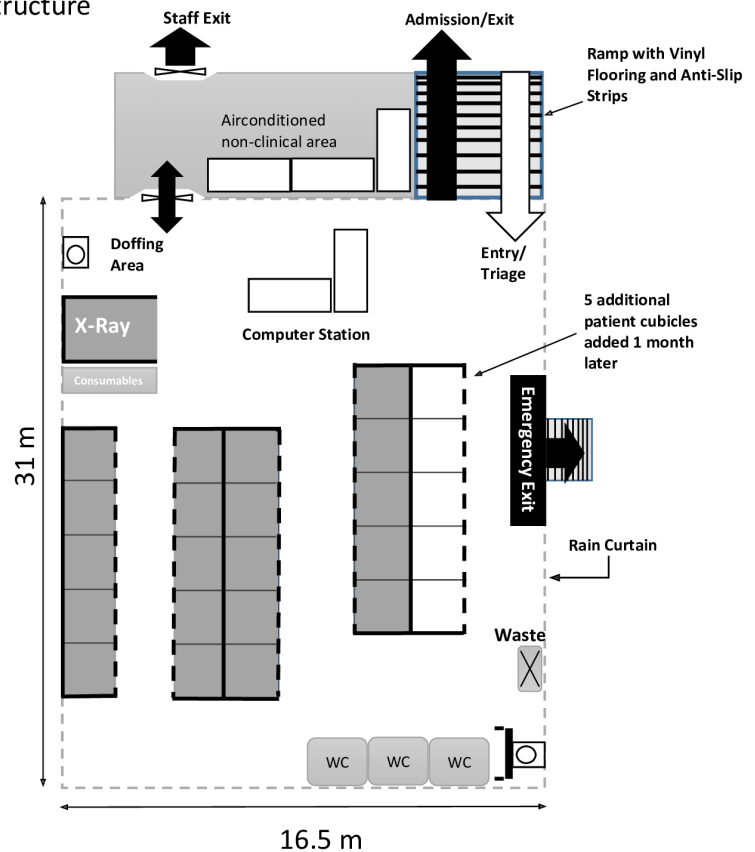
Staff working in the extension building wear long-sleeved gowns, N95 masks, gloves and eye protection at all times, changing gloves and performing hand hygiene between patients. Donning and doffing areas for personal protective equipment (PPE) were designated near entry and exit points.

Between February 14, and May 12, 2020, the EMD extension received 5,004 patients, while 9,374 patients were seen in the main EMD isolation facility. In total, 710 confirmed COVID-19 cases were managed in the NUH EMD. No infection prevention and control (IPC) breaches or exposures were observed in the EMD extension. No transmission of COVID-19 to HCWs or patients has been identified thus far at NUH.

The maximum temperature in Singapore remains 31–33°C year-round. With the use of portable cooler units and shade cover, the average internal temperature was maintained at 28.1°C, with 90% of staff stating they could wear required PPE for >1 hour without discomfort.

This report demonstrates the potential for an adapted structure to provide rapid, safe and effective surge capacity for the triage, screening and management of COVID-19 patients. This design successfully incorporated commonly sourced building materials, and natural ventilation, as a rapid solution for the screening and care of COVID-19 patients. Here, we utilized existing plumbing and water lines, but portable alternatives

A. Layout of Structure



B. Side Elevation

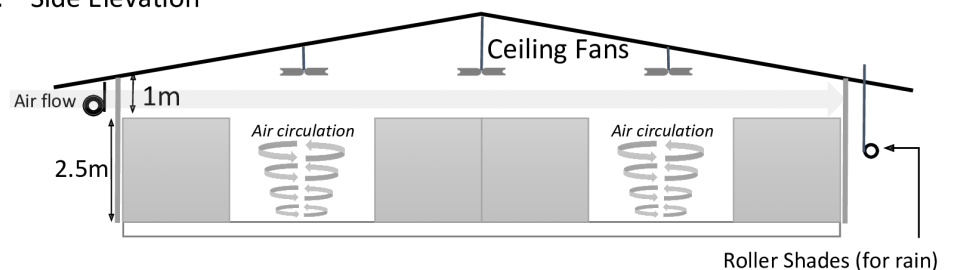


Fig. 1. Layout and side elevation of emergency medicine department extension facility. Not drawn to scale.

could be substituted. Temperature control was managed effectively with portable coolers, and in colder climates portable heaters could be adapted.

Natural ventilation, while not commonly utilized in the west, remains a common design feature for hospital wards in other parts of the world. Although AII rooms with 12 air changes per hour (ACH) have become the gold standard for airborne diseases, natural ventilation may provide rates that exceed these requirements⁸ and could represent a low-cost alternative. ACH of up to 40 have been reported in naturally ventilated structures with high ceilings,⁸ and such designs were historically used in the construction of tuberculosis wards.⁹ In recently published guidelines on the design of severe acute respiratory infection (SARI) treatment centers in limited-resource settings, natural ventilation is highlighted as one potential solution.¹⁰

Literature describing the use of natural ventilation combined with low-cost and low-tech materials for the safe management

of COVID-19 patients is scarce. This report, in conjunction with older studies recognizing the utility of natural ventilation, lends credence to the idea that low-cost, rapidly erected structures (ie, open-air tents, without HEPA filtration units) may be a solution to managing the surge of COVID-19 patients, particularly in low-income countries, or other areas with depleted medical capacity.

Acknowledgments. We thank Veera Madaan and Hospital Operations at National University Hospital for their assistance in creating the figure. We are grateful for the support of hospital leadership and operations teams in supporting the COVID-19 response and the safety of our healthcare workers, as well as our colleagues in the Emergency Medicine Department who are on the front lines.


Financial support. No financial support was provided relevant to this article.

Conflicts of interest. All authors report no competing interests.

References

1. Johnson DL, Lynch RA, Mead KR. Containment effectiveness of expedient patient isolation units. *Am J Infect Control* 2009;37:94–100.
2. Miller SL, Clements N, Elliott SA, Subhash SS, Eagan A, Radonovich LJ. Implementing a negative-pressure isolation ward for a surge in airborne infectious patients. *Am J Infect Control* 2017;45:652–659.
3. Glauser W. Proposed protocol to keep COVID-19 out of hospitals. *CMAJ* 2020;192:E264–E265.
4. Environmental control measures for airborne infection isolation surge capacity planning in health care facilities for smallpox, SARS or other infections. Potentially transmitted via airborne droplet nuclei. New York State Department of Health website. https://www.health.ny.gov/diseases/communicable/sars/preparedness_guidance/pdf/2i_surge_capacity_planning.pdf. Published December 18, 2003. Accessed June 24, 2020.
5. Frangoulidis D, Meyer H. Measures undertaken in the German Armed Forces Field Hospital deployed in Kosovo to contain a potential outbreak of Crimean-Congo hemorrhagic fever. *Military Med* 2005;170:366–369.
6. Schultz CH, Koenig KL, Alassaf W. Preparing an academic medical center to manage patients infected with Ebola: experiences of a university hospital. *Disaster Med Public Health Prep* 2015;9:558–567.
7. Sugalski G, Murano T, Fox A, Rosania A. Development and use of mobile containment units for the evaluation and treatment of potential Ebola virus disease patients in a United States hospital. *Acad Emergency Med* 2015;22:616–622.
8. Atkinson J, Chartier Y, Pessoa-Silva CL, Jensen P, Li Y, Seto WH, eds. *Natural Ventilation for Infection Control in Health-Care Settings*. Geneva: World Health Organization; 2009.
9. Escombe AR, Oeser CC, Gilman RH, *et al*. Natural ventilation for the prevention of airborne contagion. *PLoS Med* 2007;4:e68.
10. Severe acute respiratory infections treatment centre: practical manual to set up and manage a SARI treatment centre and SARI screening facility in healthcare facilities. World Health Organization website. https://apps.who.int/iris/bitstream/handle/10665/331603/WHO-2019-nCoV-SARI_treatment_center-2020.1-eng.pdf?sequence=1&isAllowed=y. Published March 2020. Accessed June 24, 2020.

Reshaping neonatal intensive care units (NICUs) to avoid the spread of severe acute respiratory coronavirus virus 2 (SARS-CoV-2) to high-risk infants

Domenico Umberto De Rose MD¹ , Cinzia Auriti MD¹, Francesca Landolfo MD¹, Irma Capolupo MD¹, Guglielmo Salvatori MD¹, Stefania Ranno MD², Carlo Concato BD², Annabella Braguglia MD³, Pietro Bagolan MD⁴ and Andrea Dotta MD¹

¹Neonatal Intensive Care Unit, Department of Medical and Surgical Neonatology, “Bambino Gesù” Children’s Hospital IRCCS, Rome, Italy, ²Virology Unit, “Bambino Gesù” Children’s Hospital IRCCS, Rome, Italy, ³Neonatal Sub-Intensive Care Unit, Department of Medical and Surgical Neonatology, “Bambino Gesù” Children’s Hospital IRCCS, Rome, Italy and ⁴Newborn Surgery Unit, Department of Medical and Surgical Neonatology, “Bambino Gesù” Children’s Hospital IRCCS, Rome, Italy

To the Editor—Italy has been hard hit by coronavirus disease 2019 (COVID-19), mostly in the northern regions,¹ while the Lazio region was partially spared. Although no evidence thus far has shown vertical transmission,^{2,3} neonatologists are concerned about preventing the spread of infection-related disease (COVID-19) in infants and healthcare workers (HCWs) of neonatal intensive care units (NICUs).⁴ Here, we report our NICU’s reorganization during the COVID-19 pandemic.

Methods

This observational study focused on infants admitted to our tertiary-care-level NICU during the COVID-19 outbreak in Italy from March 15 to May 15, 2020. Severe acute respiratory coronavirus virus 2 (SARS-CoV-2) was ruled out by nasopharyngeal swab in all infants before NICU admission. Detection of SARS-CoV-2 was performed using the Allplex 2019-nCoV assay (Seegene, Seoul, South Korea) as previously described.⁵

Author for correspondence: Domenico Umberto De Rose, E-mail: derosedomenicoumberto@gmail.com

Cite this article: De Rose DU, *et al*. (2021). Reshaping neonatal intensive care units (NICUs) to avoid the spread of severe acute respiratory coronavirus virus 2 (SARS-CoV-2) to high-risk infants. *Infection Control & Hospital Epidemiology*, 42: 632–633, <https://doi.org/10.1017/ice.2020.310>

Nasopharyngeal swabbing was performed at referring center in stable neonates. SARS-CoV-2-positive neonates were managed in a dedicated pediatric COVID-19 unit. If the swab test was negative, the newborn was referred to our non-COVID-19 NICU as usual by neonatal emergency transport service (NETS) staff. For untested babies, accurate telephone contacts between spoke and hub centers were crucial to assuring the safest pathway for admission. Newborns were managed by HCWs wearing surgical masks (when COVID-19 was not suspected and/or mothers were negative within 24 hours of life) or N95 masks (in case of suspected or confirmed SARS-CoV-2-positive newborns), gloves, eye protection, and gowns. Upon arrival at our hospital, newborns were isolated and temporarily managed by a NETS dedicated neonatologist and nurse in a separate pavilion. The staff were equipped with personal protective equipment until the negative result of the nasopharyngeal swab for SARS-CoV-2 arrived. Thereafter, the neonate could be hospitalized in our NICU in a room with other infants.

Infants admitted to the emergency department (ED) were tested for SARS-CoV-2 on arrival and remained there until the negative result was available prior to NICU admission.

In the NICU, disposable surgical masks were always required for HCWs; body temperature was measured every day for all HCWs. Parental visits are still restricted to 6 hours each day, and only 1 parent is allowed for each baby, after signing a self-