

- if any suspected in-patient meeting the case definition undergoes an aerosol generating procedure (AGP), then an FFP3 respirator, long-sleeved disposable fluid-repellent gown, gloves and eye protection must be worn.

5. . Aerosol generating procedures

- The agreed list for AGP is:
 - Intubation, extubation and related procedures e.g. manual ventilation and open suctioning.
 - Tracheotomy/tracheostomy procedures (insertion/open suctioning/removal)
 - Bronchoscopy.
 - Surgery and post-mortem procedures involving high-speed devices.
 - Some dental procedures (e.g. high-speed drilling).
 - Non-invasive ventilation (NIV) e.g. Bi-level Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure ventilation (CPAP).
 - High-Frequency Oscillating Ventilation (HFOV)
 - High Flow Nasal Oxygen HFNO (also called High Flow Nasal Cannula)
 - Induction of sputum

Where these procedures are medically necessary, they should be undertaken in a negative-pressure room, if available, or in a single room with the door closed.

Note: Administration of medication via nebulisation is **not** an APG. During nebulisation, the aerosol derives from a non-patient source (the fluid in the nebuliser chamber) and does not carry patient-derived viral particles. If a particle in the aerosol coalesces with a contaminated mucous membrane, it will cease to be airborne and therefore will not be part of an aerosol. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and/or oxygen masks.

Only the minimum number of required staff should be present, and they must all wear PPE as described above. Entry and exit from the room should be minimised during the procedure.

If aerosol generating procedures are undertaken in the patient's own room, the room should be decontaminated 20 minutes after the procedure has ended.

If a different room is used for a procedure it should be left for 20 minutes, then cleaned and disinfected before being put back into use.

Clearance of any aerosols is dependent on the ventilation of the room. In hospitals, rooms commonly have 12-15 air changes per hour, and so after about 20 minutes, there would be less than 1 per cent of the starting level (assuming cessation of aerosol generation).

If it is known locally that the design or construction of a room may not be typical for a clinical space, or that there are fewer air changes per hour, then the local IPCT would advise on how long to leave a room before decontamination.