COVID-19 Provincial Guidance for Aerosol Generating Medical Procedures (AGMPs)

Note: latest updates will appear in blue

As the COVID-19 situation evolves and more data becomes available this guidance will be modified as the new evidence is reviewed.

In order to minimize the risk of staff being identified as high-risk contacts, modifications have been made to the guidelines for Green Zone Aerosol Generating Medical Procedures (AGMPs).

STRATEGIES TO REDUCE RISK FROM AGMPs

1. Carefully analyze risks and benefits to AGMPs; avoid performing unnecessary AGMPs.
2. Consider alternative to AGMPs.
3. Anticipate and plan for AGMPs.
4. Depending on the procedure, sedation may be appropriate for the person requiring the AGMP, to minimize excessive and/or prolonged and/or forceful coughing etc.
5. Paralytics to minimize the risk of aerosolization (for intubation or if the patient’s breathing is already supported by mechanical ventilation) can be used when appropriate.
6. Use closed endotracheal suction systems whenever possible.
7. Use the minimum required number of staff in the room when performing an AGMP.
8. Ensure appropriate PPE is worn by all staff present in the room during the procedure.
9. Choose an appropriate space for an AGMP. The appropriate space for an AGMP will vary depending on the patient and the circumstances in which the AGMP is taking place and is further described in this document.

ACCOMMODATION AND PERSONAL PROTECTIVE EQUIPMENT (PPE)

To categorize risk and allocate appropriate accommodation for persons confirmed or suspected of being infected with COVID-19, a classification system has been created to designate the type of PPE required for interacting with patients, residents and clients who are receiving care/being assessed or managed in specific settings or specific zones. The specifics can be found in the COVID-19 Personal Protective Equipment Supply Management and Stewardship Planning and Guidance Framework and the Provincial Personal Protective Equipment Requirements document.
PROCEDURE

1. Medical Procedures Considered to Be AGMPs

   The following medical procedures outlined in Table 1 have been considered as AGMPs after review of existing data and separated by potential risk of infection transmission:

   **TABLE 1: Medical Procedures Considered to be AGMPs**

<table>
<thead>
<tr>
<th>Medical Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endotracheal intubation and extubation, manual bag mask ventilation</td>
</tr>
<tr>
<td>Bronchoscopy and bronchoalveolar lavage</td>
</tr>
<tr>
<td>Tracheostomy procedure (open or percutaneous)</td>
</tr>
<tr>
<td>Laryngoscopy</td>
</tr>
<tr>
<td>Non-invasive positive pressure ventilation (BiPAP and CPAP)</td>
</tr>
<tr>
<td>High flow nasal cannula oxygenation (e.g. Optiflow) - should only be used in patients with COVID-19 following consultation with an Attending Intensivist</td>
</tr>
<tr>
<td>* Note: Oxygen delivered via nasal prongs and/or non-rebreath masks are not considered AGMP, regardless of flow rate</td>
</tr>
<tr>
<td>Some dental procedures (e.g., high speed drilling, ultrasonic scalers etc.)</td>
</tr>
<tr>
<td>Autopsy of lung tissue</td>
</tr>
<tr>
<td>Sputum induction using hypertonic saline</td>
</tr>
<tr>
<td>Cardiopulmonary resuscitation (with manipulation of the airway)</td>
</tr>
<tr>
<td>*Note: Chest compressions are not considered AGMP</td>
</tr>
<tr>
<td>Open deep suctioning via endotracheal tube/tracheostomy tube</td>
</tr>
<tr>
<td>Administration of nebulizing medications, does not include administration of a metered dose inhaler (MDI)</td>
</tr>
</tbody>
</table>

   **CLARIFICATION:** *Collection of nasopharyngeal swabs and/or nasopharyngeal aspirates are not considered AGMPs, there is no published literature documenting transmission of respiratory infections, including TB, SARS, influenza, and COVID-19 by collection of these specimens.*

2. Guidance for Patient/Resident/Client Populations

   For patients, residents, clients designated in the following categories:

   - Designated as “RED” or “ORANGE” zone
   - Designated as “GREEN” Zone admitted to hospital/resident in long term care for less than 14 days (<14 days)
   - Designated as “GREEN” Zone where there is clinical concern of infection with an airborne pathogen such as *Mycobacterium tuberculosis*; OR
   - Designated “GREEN” Zone where the patient/resident/client is demonstrating new onset of respiratory symptoms of an infectious nature and is being assessed for COVID-19 testing and as a result, their status is being changed to “ORANGE”.

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For all AGMPs performed on patients/residents/clients in the above categories, health care workers in the room during the AGMP are required to wear an N95 respirator and eye protection. The number of health care workers in the room should be limited to only those necessary for the procedure. Refer to Table 2 for AGMP Accommodation Requirements.

**TABLE 2: AGMP Accommodation Requirements, Cohorting Recommendations**

<table>
<thead>
<tr>
<th>Patient/Resident/Client Population</th>
<th>AGMP Accommodation Requirements / Cohorting Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>RED</td>
<td>AIIR/Private Room Door Closed wherever possible.</td>
</tr>
<tr>
<td></td>
<td>Cohorting with another RED or COVID-19 recovered patient/resident is only acceptable if no alternative exists.</td>
</tr>
<tr>
<td></td>
<td>For designated RED Zone units refer to appropriate PPE Requirements.</td>
</tr>
<tr>
<td>ORANGE</td>
<td>AIIR/Private Room Door Closed Required wherever operationally feasible.</td>
</tr>
<tr>
<td></td>
<td>If AIIR/Private Room is not feasible then cohorting with COVID-19 Recovered patient/resident is acceptable.</td>
</tr>
<tr>
<td>GREEN &lt;14 Days Admitted</td>
<td>AIIR/Private Room Door Closed Required wherever operationally feasible</td>
</tr>
<tr>
<td></td>
<td>If AIIR/Private Room is not feasible:</td>
</tr>
<tr>
<td></td>
<td>• First choice - Cohort with COVID-19 Recovered patient/resident</td>
</tr>
<tr>
<td></td>
<td>• Second choice – Cohort with Green Zone patient/resident</td>
</tr>
<tr>
<td>GREEN with clinical concern of infection with an airborne pathogen such as <em>Mycobacterium tuberculosis</em></td>
<td>AIIR/Private Room Door Closed Required</td>
</tr>
<tr>
<td></td>
<td>Do not cohort</td>
</tr>
<tr>
<td>Green &gt;14 Days Admitted</td>
<td>AIIR/Private Room Door Closed Preferred, Not Required</td>
</tr>
<tr>
<td></td>
<td>Best options for cohorting:</td>
</tr>
<tr>
<td></td>
<td>• First choice - Cohort with COVID-19 Recovered patient/resident</td>
</tr>
<tr>
<td></td>
<td>• Second choice – Cohort with Green Zone &gt;14 Days</td>
</tr>
</tbody>
</table>
• Third choice – Cohort with Green Zone <14 Days patient/resident.

For patients or residents designated in the following categories, follow the guidance below:

• For patients and residents designated as “GREEN” zone admitted to hospital or resident in long term care for longer than 14 days (>14 days), all health care workers in the room during an AGMP are required to wear an N95 respirator and eye protection. The number of health care workers in the room should be limited to only those necessary for the procedure. Refer to chart for AGMP Accommodation Requirements.

• For patients designated as “GREEN” zone, including surgical, labour and delivery and select other patients, refer to the “Aerosol-Generating Medical Procedures (AGMPs) and Duration of Validity for a Negative COVID-19 Test Result “Same Day, Next Day” AGMP Rule” to guide decisions regarding PPE and OR procedures for AGMPs [https://sharedhealthmb.ca/files/covid-19-agmps-and-negative-test.pdf](https://sharedhealthmb.ca/files/covid-19-agmps-and-negative-test.pdf).

In addition, the following procedures ARE NOT deemed AGMPs. However, out of an abundance of caution, for the procedures specified below only, use of an N95 respirator is recommended for patients/residents/clients with suspected or confirmed COVID-19 disease (ORANGE or RED zone patients), and the procedures should be done in an AIIR or Private Room if possible:

- Chest tube insertion for pneumothorax
- Oral suctioning in intubated and ventilated patients
- Routine tracheostomy care such as dressing changes, application of acetic acid soaks, cleaning the neck area or the tracheostomy, changing the inner cannula
- Large volume nebulizers (e.g., cold pot)
- Breaks in the ventilator circuit
- Upper gastrointestinal endoscopy and/or nasogastric/nasojejunal tube placements
- Transesophageal echocardiography
- Flexible nasopharyngolaryngoscopy

3. ZONE Status before and after AGMP

   The requirement to use an N95 respirator for an AGMP in a “GREEN” Zone patient/resident/client DOES NOT result in the individual being considered “ORANGE” Zone.

4. Airborne Infection Isolation Rooms and Private Rooms with Doors Closed:
• An AIIR is a single-occupancy patient care room used to isolate those with suspected or confirmed airborne infectious diseases. This type of isolation room provides a more rapid removal of airborne infectious particles from the patient care environment to the outdoors, and with the negative airflow/pressure into the room, reduces movement of aerosols out of the room to the hallway. When AGMPs are performed, high airflow rates and negative pressure airflow allows for a more rapid clearing of the particles that have been aerosolized and contains them within the room.

• Choose an appropriate space for an AGMP. Identify and label AIIR for AGMPs so staff are easily aware. Refer to section below *Airborne Infection Isolation Rooms and Private Rooms with Doors Closed* and *AGMP Environmental Controls* and COVID-19 Specific Disease Protocol – Acute & Community Settings (Winnipeg and Provincial).

• It is not mandatory for AGMPs to occur in airborne infection isolation rooms (AIIR) which achieve a “negative pressure” by means of exhausting more air (to the outside of the facility) than air that is supplied. Note: there are risks associated with transferring patients to/from AIIR (increased risk of contaminating other patients, HCW and other hospital environments). These must be balanced with the small theoretical benefit of using AIIRs for AGMPs.

• When an AIIR is not used for AGMPs: use a single room and keep door closed until air clearance is achieved (refer to Section 4 below: *AGMP Environmental Controls*). Staff may leave the AIIR or single room after the AGMP is completed but movement in and out of the room should be for essential activities only the period afterwards where the air in the room is being “cleaned” by air exchange. Open and close the door slowly during this time to minimize “dragging” air from the room.

• When neither an AIIR or single room with door closed are used for an AGMP, draw the privacy curtains and remove any shared equipment, supplies or linens from the immediate vicinity prior to performing an AGMP.

Following an AGMP in an AIIR that has 12 air changes per hour (ACH), staff must wear an N95 respirator when in the room AND the door must be kept closed, and in/out traffic minimized for no less than 23 minutes following completion of the AGMP for 99% clearance.

Following an AGMP in a standard single (private) room or in semi-private or open rooms, that has less air exchanges per hour, staff must wear an N95 respirator when in the room AND the door must be kept closed following completion of the AGMP as outlined below (refer to section below on AGMP Environmental Controls).

3. Special considerations for all AGMPs in all Health Care Settings (e.g., acute, long term care, and community), regardless of patient infection status:
All HCW present during the performance of an AGMP are required to wear an N95 respirator and eye protection. A point of care risk assessment (PCRA) for COVID-19 is not required in order for health care workers present during an AGMP to be provided an N95. In an emergency situation where clinical assessment is not possible, the highest level of protection (N95 respirator) should be used.

4. AGMP Environmental Controls

When AGMPs are anticipated, consult with management to identify appropriate rooms and/or environments for AGMP’s.

If AGMPs must be urgently performed prior to placing a patient in a single patient room, the following precautions should be taken:

- Maintain physical separation of spaces with curtains and draw close
- If present, HEPA filtration systems should be started prior to the start of any AGMP’s by clinical staff and remain on until a suitable (calculated) air clearance time has occurred. This time will vary depending upon the ventilation system characteristics, air volume of the HEPA unit, and space enclosed by the curtain. Clinical staff should limit their movement in/out of the curtain during this time to minimize airborne contamination of the adjacent spaces

Always confirm with site Facility Management the air change rates for your site.

Air clearance time is the time required for 99% dilution of any aerosol:

- Assume air clearance time to be 3 hours unless confirmed with site Facility Management otherwise. (3 hours is based upon a minimal 2 air changes per hour [ACH])
- Typical air clearance times in newer ventilated spaces are:
  - Inpatient room (6 ACH): 46 minutes for 99% air clearance.
  - Airborne infection isolation room (negative pressure) (12 ACH): 23 minutes for 99% air clearance.
  - Resuscitation Room (15 ACH): 18 minutes for 99% air clearance.
  - Operating Theatre (20 ACH): 14 minutes for 99% air clearance.
- Where a supplemental HEPA scrubber is used, air clearance times must be determined with site Facility Management.

Change Log:

January 15, 2021:

- Updated to include Table 2 for AGMP Accommodation (pg. 3).
• Updated guidance for resident and client populations, including required N95 respirator for all health care workers in the room where AGMPs are performed, regardless of Zone (Green, Orange, Red), duration of admission/LOS, or setting (Acute, Long Term Care, Community).

• This update extends the guidance included in the December 24, 2020 update to long term care and community environments. As such, the December 24, 2020 updates remain in blue.

December 24, 2020:

• Updated guidance for inpatient populations, including required N95 respirator for all health care workers in the room when AGMPs are performed on Green Zone patients, regardless of the duration of their admission/LOS.

• Background Information moved to the end of the document as reference for information.

December 3, 2020:


Oct. 27, 2020:

• Table 1 update to include Green Zone patients who have been hospitalized for less than 14 days (pg. 3)
• Update to include recommendation for use of private room and N95 respirator for AGMPs involving Green Zone patients who have been hospitalized for less than 14 days (pg. 5)
• Update to include recommendation “out of an abundance of caution” for use of N95 respirator with Orange and Red Zone patients for specified procedures (pg. 6)
• Document updated to reflect 99% air clearance (pg. 6)

Oct. 8, 2020:

• Added Large volume nebulizers (e.g., cold pot) to list of procedures that are not deemed AGMPs (pg. 6)

Sept. 30, 2020:

• Update of IP&C Requirements (removal of influenza from list of at risk opportunistic airborne transmission of pathogens not otherwise spread by the airborne route)
• Update of air clearance time details (pg. 5)
• Update to procedures that ARE NOT deemed AGMPs and those procedures for which an N95 respirator should be used (pg. 6)
ADDITIONAL BACKGROUND

Aerosol generating medical procedures (AGMPs) are any procedure carried out on a patient/resident/client that can induce the production of aerosols of various sizes, including droplet nuclei.

Medical procedures that generate aerosols or droplet nuclei in high concentration present a risk for opportunistic airborne transmission of pathogens not otherwise spread by the airborne route (e.g., SARS) and increase the risk for transmission of organisms known to spread by the airborne route (e.g., Mycobacterium tuberculosis).

The Public Health Agency of Canada (PHAC) guideline (adhered to by Manitoba Health, Seniors and Active Living) outlines precautions for the prevention of transmission of infection in the health care environment.

Droplets are produced in various ways (e.g. sneezing, coughing, singing) and they vary in size. Large droplets (> 5 μm) are most of the volume of expelled respiratory droplets (> 99%); these tend to fall rapidly to the ground, usually within a distance of 1 meter or less. Droplets smaller than 5 μm (e.g. droplet nuclei) may remain suspended in the air for significant periods of time and move with air currents. Respiratory viruses, including COVID-19 are usually transported in large particle droplets. As enveloped viruses, they are usually not viable in small droplet-nuclei. When patients cough, sneeze, or vomit, droplets are created and land on nearby surfaces, however medical procedures that induce coughing, sneezing, or vomiting are not in themselves AGMPs.

Droplet transmission occurs when bacteria or viruses travel on relatively large respiratory droplets that people sneeze, cough, or exhale (by talking or heavy breathing). They travel only short distances (less than 2 meters) before settling onto nearby surfaces. These droplets may be loaded with infectious particles and can infect another person if the bacteria/viruses directly contact the eyes, nose or mouth of another individual prior to settling onto nearby surfaces. Once they fall onto surfaces, they may be transferred onto someone’s hands and infection may occur if the eyes, nose or mouth are touched by contaminated surfaces (e.g. hands).

Airborne transmission occurs when bacteria or viruses travel in droplet nuclei that become aerosolized. Healthy people can inhale the infectious droplet nuclei into their lungs. Recent systematic reviews have concluded that in the clinical environment there is no compelling evidence that N95 respirators were superior to procedure or surgical masks with eye protection for protecting health care workers (HCWs) against droplet borne respiratory infections. For these reasons and consistent with recommendations from the PHAC and World Health Organization (WHO), health care workers are recommended to wear a procedure or
surgical mask with eye protection as well as gloves and gown for most care for a person confirmed or suspected to have COVID-19.

**AGMPs are the exception.** AGMPs generate aerosols and small droplet nuclei *in high concentrations*. These droplet nuclei may contain bacteria or viruses that could present a risk for opportunistic airborne transmission of pathogens not otherwise able to spread by the airborne route (e.g., SARS-CoV1, SARS-CoV2). While there is no conclusive evidence that opportunistic airborne transmission occurs after all AGMPs, enhanced safeguards are recommended when performing AGMPs to reduce the likelihood of transmission to health care workers.