REHVA
Federation of European Heating, Ventilation and Air Conditioning Associations

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(this document updates March 17 version, updates will follow as necessary)

How to operate and use building services in order to prevent the spread of the coronavirus disease (COVID-19) virus (SARS-CoV-2) in workplaces

Introduction

In this document REHVA summarizes advice on the operation and use of building services in areas with a coronavirus disease (COVID-19) outbreak, in order to prevent the spread of COVID-19 depending on HVAC or plumbing systems related factors. Please read the advice below as *interim* guidance; the document may be complemented with new evidence and information when it becomes available.

The suggestions below are meant as an addition to the general guidance for employers and building owners that is presented in the WHO document 'Getting workplaces ready for COVID-19'. The text below is intended primarily for HVAC professionals and facility managers, but may be useful for e.g. occupational and public health specialists.

In the following the building related precautions are covered and some common overreactions are explained. The scope is limited to commercial and public buildings (e.g. offices, schools, shopping areas, sport premises etc) where only occasional occupancy of infected persons is expected; hospital and healthcare facilities (usually with a larger concentration of infected people) are excluded.

The guidance is focused to temporary, easy-to-organize measures that can be implemented in existing buildings which are still in use with normal occupancy rates. The advice is meant for a short period depending on how long local outbreaks last.

Disclaimer:
This REHVA document is based on best available evidence and knowledge, but in many aspects' corona virus (SARS-CoV-2) information is so limited or not existing that previous SARS-CoV-1 evidence[1] has been utilized for best practice recommendations. REHVA excludes any liability for any direct, indirect, incidental damages or any other damages that would result from, or be connected with the use of the information presented in this document.

[1] In the last two decades we are confronted with three coronavirus disease outbreaks: (i) SARS in 2002-2003 (SARS-CoV-1), (ii) MERS in 2012 (MERS-CoV) and Covid-19 in 2019-2020 (SARS-CoV-2). In the present document our focus is on the last aspect of SARS-CoV-2 transmission. When it is referred to the SARS outbreak in 2002-2003 we will use the name of SARS-CoV-1 virus at that time.

Transmission routes

Important for every epidemic are the transmission routes of the infectious agent. In relation to COVID-19 the standard assumption is that the following two transmission routes are dominant: via large droplets (droplets/particles emitted when sneezing or coughing or talking) and via surface (fomite) contact (hand-hand, hand-surface etc.). A third transmission route that is gaining more attention from the scientific community is the faecal-oral route.

The faecal-oral transmission route for SARS-CoV-2 infections is implicitly recognized by WHO, see their latest technical briefing of March 2, 2020[i]. In this document they propose as precautionary measure to flush toilets with closed lid. Additionally, they suggest avoiding dried-out drains in floors and other sanitary devices by regularly adding water (every 3 weeks depending on climate) so that the water seal works properly. This is in line with an observation during the SARS 2002-2003 outbreak: open connections with sewage systems appeared to be a transmission route in an apartment building in Hong Kong (Amoy Garden)[ii]. It is known that flushing toilets are creating plumes containing droplets and droplet residue when toilets are flushed with open lids. And we know that SARS-CoV-2 viruses have been detected in stool samples (reported in recent scientific papers and by the Chinese authorities)[iii,iv,v]. In addition, a comparable incident was recently reported in an apartment complex (Mei House). Therefore, the conclusion is that the faecal-oral transmission routes can't be excluded as transmission route.

Via air there are two exposure mechanisms[vi,vii]:

1. Close contact transmission through large droplets (> 10 microns), which are released and fall to surfaces not further than about 1-2 m from the infected person. Droplets are formed from coughing and sneezing (sneezing forms many more particles typically). Most of these large droplets fall on nearby surfaces and objects – such as desks and tables. People could catch the infection by touching those contaminated surfaces or objects; and then touching their eyes, nose or mouth. If people are standing within 1-2 meter of an infected person, they can catch it directly by breathing in droplets sneezed or coughed out or exhaled by them.
2. Airborne transmission through small particles (< 5 microns), which may stay airborne for hours and can be transported long distances. These are also generated by coughing and sneezing and talking. Small particles (droplet nuclei or residue) form from droplets which evaporate (10 microns droplets evaporate in 0.2 s) and desiccate. The size of a coronavirus particle is 80-160 nanometre[2,viii] and it remains active for many hours or couple of days (unless there is specific cleaning)[ix,x,xi]. SARS-CoV-2 remains active up to 3 hours in indoor air and 2-3 days on room surfaces at common indoor conditions[xii]. Such small virus particles stay airborne and can travel long distances carried by airflows in the rooms or in the extract air ducts of ventilation systems. Airborne transmission has caused infections of SARS-CoV-1 in the past[xiii,xiv]. For Corona disease (COVID-19) it is likely but not yet documented. There is also no reported data or studies to rule out the possibility of the airborne-particle route. One indication for this: Corona virus SARS-CoV-2 has been isolated from swabs taken from exhaust vents in rooms occupied by infected patients. This mechanism implies that keeping 1-2 m distance from infected persons might not be enough and increasing the ventilation is useful because of removal of more particles[3].

[2] 1 nanometer = 0.001 micron

[3] Personal respiratory protection measures such as respirators and solid visors are out of the scope of this document.

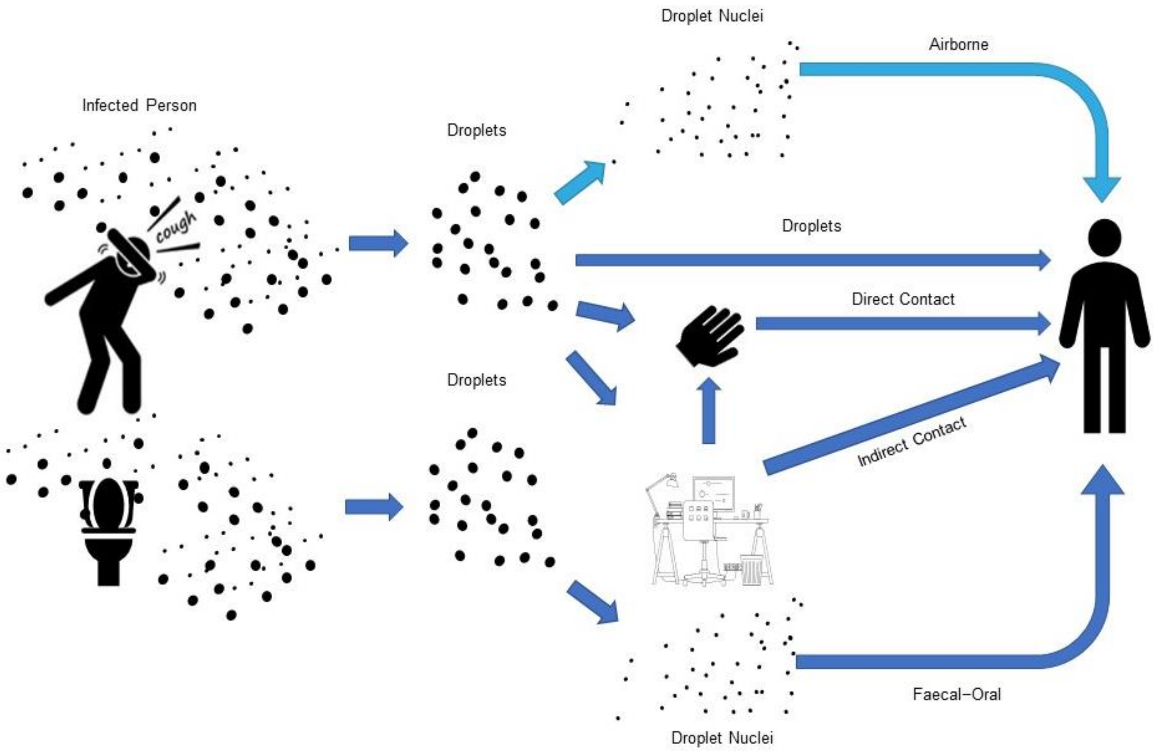

Figure 1. WHO reported exposure mechanisms of COVID-19 SARS-CoV-2 droplets (dark blue colour). Light blue colour: airborne mechanism that is known from SARS-CoV-1 and other flu, currently there is no reported evidence specifically for SARS-CoV-2 (figure: courtesy Francesco Franchimon).

With SARS-CoV-2 the airborne route – infection through exposure to droplet nuclei particles – has currently acknowledged by WHO for hospital procedures and indirectly through the guidance to increase ventilation[xv]. It may exist when certain conditions are met (i.e. opportunistic airborne) according to China national Health Commission (unpublished result). Airborne transmission can be possible according to Japanese authority under certain circumstances, such as when talking to many people at a short distance in an enclosed space, there is a risk of spreading the infection even without coughing or sneezing[xvi]. Latest study[xvii] concluded that aerosol transmission is plausible, as the virus can remain viable in aerosols for multiple hours. Another recent study[xviii] that analysed superspreading events showed that closed environments with minimal ventilation strongly contributed to a characteristically high number of secondary infections. The manuscript draft discussing airborne transmission concludes that evidence is emerging indicating that SARS-CoV-2 is also transmitted via airborne particles[xix].

Conclusion in relation to the airborne transmission route:
At this date we need all efforts to manage this pandemic from all fronts. Therefore REHVA proposes, especially in 'hot spot' areas to use the ALARA principle (As Low As Reasonably Achievable) and to take a set of measures that help to also control the airborne route in buildings (apart from standard hygiene measures as recommended by WHO, see the 'Getting workplaces ready for COVID-19' document).

Practical recommendations for building services operation

Increase air supply and exhaust ventilation
In buildings with mechanical ventilation systems extended operation times are recommended. Change the clock times of system timers to start ventilation at nominal speed at least 2 hours before the building usage time and switch to lower speed 2 hours after the building usage time. In demand-

controlled ventilation systems change CO_2 setpoint to lower, 400 ppm value, in order to assure the operation at nominal speed. Keep the ventilation on 24/7, with lowered (but not switched off) ventilation rates when people are absent. In buildings that have been vacated due to the pandemic (some offices or educational buildings) it is not recommended to switch ventilation off, but to operate continuously at reduced speed. Considering a springtime with small heating and cooling needs, the recommendations above have limited energy penalties, while they help to remove virus particles out of the building and to remove released virus particles from surfaces.
The general advice is to supply as much outside air as reasonably possible. The key aspect is the amount of fresh air supplied per person. If, due to smart working utilization, the number of employees is reduced, do not concentrate the remaining employees in smaller areas but maintain or enlarge the social distancing (min physical distance 2-3 m between persons) among them in order to foster the ventilation cleaning effect.
Exhaust ventilation systems of toilets should always be kept on 24/7, and make sure that under-pressure is created, especially to avoid the faecal-oral transmission.

Use more window airing
General recommendation is to stay away from crowded and poorly ventilated spaces. In buildings without mechanical ventilation systems it is recommended to actively use operable windows (much more than normally, even when this causes some thermal discomfort). Window airing then is the only way to boost air exchange rates. One could open windows for 15 min or so when entering the room (especially when the room was occupied by others beforehand). Also, in buildings with mechanical ventilation, window airing can be used to further boost ventilation.
Open windows in toilets with passive stack or mechanical exhaust systems may cause a contaminated airflow from the toilet to other rooms, implying that ventilation begins to work in reverse direction. Open toilet windows then should be avoided. If there is no adequate exhaust ventilation from toilets and window airing in toilets cannot be avoided, it is important to keep windows open also in other spaces in order to achieve cross flows throughout the building.

Humidification and air-conditioning have no practical effect
Relative humidity (RH) and temperature contribute to virus transmission indoors affecting virus viability, droplet nuclei forming and susceptibility of occupants' mucous membranes. Transmission of some viruses in buildings can be limited by changing air temperatures and humidity levels. In the case of COVID-19 this is unfortunately not an option as coronaviruses are quite resistant to environmental changes and are susceptible only for a very high relative humidity above 80% and a temperature above 30 °C[ix,x,xi], which are not attainable and acceptable in buildings for other reasons (e.g. thermal comfort and microbial growth). SARS-CoV-2 has been found highly stable for 14 days at 4 ℃; 37 ℃ for one day and 56 ℃ for 30 minutes were needed to inactivate the virus[xx].
SARS-CoV-2 stability (viability) has been tested at typical indoor temperature of 21-23 ℃ and RH of 65% with very high virus stability at this RH[xxi]. Together with previous evidence on MERS-CoV it is well documented that humidification up to 65% may have very limited or no effect on stability of SARS-CoV-2 virus. Therefore, the evidence does not support that moderate humidity (RH 40-60%) will be beneficial in reducing viability of SARS-CoV-2, thus the humidification is NOT a method to reduce the viability of SARS-CoV-2.
Small droplets under interest (0.5 – 10 micron) will evaporate fast under any relative humidity (RH) level[xxii]. Nasal systems and mucous membranes are more sensitive to infections at very low RH of 10-20 %[xxiii,xxiv], and this is the reason for which some humidification in winter is sometimes suggested (to levels of 20-30%). This indirect need for humidification in winter in the COVID-19 case is not relevant however given the incoming climatic conditions (from March onwards we expect indoor RH higher than 30% in all European climates without humidification).
Thus, in buildings equipped with centralized humidification, there is no need to change humidification systems' setpoints (usually 25 or 30%[xxv]). Considering the springtime that is about to start, these systems should not be in operation anyhow. Heating and cooling systems can be operated

normally as there are no direct implications on COVID-19 spread. Usually, any adjustment of setpoints for heating or cooling systems is not needed.

Safe use of heat recovery sections

Under certain conditions virus particles in extract air can re-enter the building. Heat recovery devices may carry over virus attached to particles from the exhaust air side to the supply air side via leaks.

Regenerative air to air heat exchangers (i.e. rotors, called also enthalpy wheels) may be sensitive for considerable leaks in the case of poor design and maintenance. For properly operating rotary heat exchangers, fitted with purging sectors and correctly set up, leakage rates are about the same as that of plate heat exchangers being in the range of 1-2%. For existing systems, the leakage should be below 5%, and has to be compensated with increase of outdoor air ventilation according to EN 16798-3:2017. However, many rotary heat exchangers may not be properly installed. The most common fault is that the fans have been mounted in such a way that higher pressure on the exhaust air side is created. This will cause leakage from extract air into the supply air. The degree of uncontrolled transfer of polluted extract air can in these cases be of the order of 20%[xxvi], that is not acceptable.

It is shown that rotary heat exchangers, which are properly constructed, installed and maintained, have almost zero transfer of particle-bound pollutants (including air-borne bacteria, viruses and fungi), but the transfer is limited to gaseous pollutants such as tobacco smoke and other smells[xxvii]. Thus, there is no evidence that virus-bearing particles starting from 0.1 micron would be an object of carry over leakage. Because the leakage rate does not depend on the rotation speed of rotor, it is not needed to switch rotors off. Normal operation of rotors makes it easier to keep ventilation rates higher. It is known that the carry-over leakage is highest at low airflow, thus higher ventilation rates are recommended.

If leaks are suspected in the heat recovery sections, pressure adjustment or bypassing (some systems may be equipped with bypass) can be an option in order to avoid a situation where higher pressure on extract side will cause air leakages to supply side. Pressure differences can be corrected by dampers or by other reasonable arrangements. In conclusion, we recommend to inspect the heat recovery equipment including the pressure difference measurement. To be on the safe side, the maintenance personnel should follow standard safety procedures of dusty work, including wearing gloves and respiratory protection.

Virus particle transmission via heat recovery devices is not an issue when a HVAC system is equipped with a twin coil unit or another heat recovery device that guarantees 100% air separation between return and supply side[xxviii].

No use of recirculation

Virus particles in return ducts can also re-enter a building when centralized air handling units are equipped with recirculation sectors. It is recommended to avoid central recirculation during SARS-CoV-2 episodes: close the recirculation dampers (via the Building Management System or manually). In case this leads to problems with cooling or heating capacity, this has to be accepted because it is more important to prevent contamination and protect public health than to guarantee thermal comfort.

Sometimes air handling units and recirculation sections are equipped with return air filters. This should not be a reason to keep recirculation dampers open as these filters normally do not filter out particles with viruses effectively since they have standard efficiencies (G4/M5 or ISO coarse/ePM10 filter class)[xxix] and not HEPA efficiencies.

Some systems (fan coil and induction units) work with local (room level) circulation. If possible (no significant cooling need) these units are recommended to be turned off to avoid resuspension of virus particles at room level (esp. when rooms are used normally by more than one occupant). Fan coil units have coarse filters which practically do not filter small particles but still might collect particles. On the fan coil heat exchanger surface, it is possible to inactivate the virus by heating up fan coils to 60 °C during one hour or 40 °C during one day.

If fan coils cannot be switched off, it is recommended that their fans are operated continuously because the virus can sediment in filters and resuspension boost can follow when the fan is turned on. In continuous circulation operation virus particles will be removed with exhaust ventilation.

Duct cleaning has no practical effect

There have been overreactive statements recommending to clean ventilation ducts in order to avoid SARS-CoV-2 transmission via ventilation systems. Duct cleaning is not effective against room-to-room infection because the ventilation system is not a contamination source if above guidance about heat recovery and recirculation is followed. Viruses attached to small particles will not deposit easily in ventilation ducts and normally will be carried out by the air flow anyhow[xxx]. Therefore, no changes are needed to normal duct cleaning and maintenance procedures. Much more important is to increase fresh air supply, avoid recirculation of air according to the recommendations above.

Change of outdoor air filters is not necessary

In COVID-19 context, it has been asked should the filters to be replaced and what is the protection effect in very rare occasions of outdoor virus contamination, for instance if air exhausts are close to air intakes. Modern ventilation systems (air handling units) are equipped with fine outdoor air filters right after the outdoor air intake (filter class F7 or F8[4] or ISO ePM2.5 or ePM1) which filtrate well particulate matter from outdoor air. The size of a naked coronavirus particle of 80-160 nm[viii] (PM0.1) is smaller than the capture area of F8 filters (capture efficiency 65-90% for PM1), but many of such small particles will settle on fibres of the filter by diffusion mechanism. SARS-CoV-2 particles also aggregate with larger particles which are already within the capture area of filters. This implies that in rare cases of virus contaminated outdoor air, standard fine outdoor air filters provide a reasonable protection for a low concentration and occasionally spread viruses in outdoor air.

Heat recovery and recirculation sections are equipped with less effective extract air filters (G4/M5 or ISO coarse/ePM10) which aim is to protect equipment from dust. These filters do not have to filter out small particles as virus particles will be ventilated out by exhaust air (see also the recommendation not to use recirculation under 'no use of recirculation').

From the filter replacement perspective, normal maintenance procedures can be used. Clogged filters are not a contamination source in this context, but they reduce supply airflow which has a negative effect on indoor contaminations itself. Thus, filters must be replaced according to normal procedure when pressure or time limits are exceeded, or according to scheduled maintenance. In conclusion, we do not recommend changing existing outdoor air filters and replace them with other type of filters nor do we recommend changing them sooner than normal.

HVAC maintenance personnel could be at risk when filters (especially extract air filters) are not changed in line with standard safety procedures. To be on the safe side, always assume that filters have active microbiological material on them, including viable viruses. This is particularly important in any building where there recently has been an infection. Filters should be changed with the system turned off, while wearing gloves, with respiratory protection, and disposed of in a sealed bag.

Room air cleaners can be useful in specific situations

Room air cleaners remove effectively particles from air which provides a similar effect compared to ventilation. To be effective, air cleaners need to have at least HEPA filter efficiency. Unfortunately, most of attractively priced room air cleaners are not effective enough. Devices that use electrostatic filtration principles (not the same as room ionizers!) often work quite well too. Because the airflow through air cleaners is limited, the floor area they can effectively serve is normally quite small, typically less than 10 m^2. If one decides to use an air cleaner (again: increasing regular ventilation often is much more efficient) it is recommended to locate the device close to the breathing zone. Special UV cleaning equipment to be installed for the supply air or room air treatment is also effective

[4] An outdated filter classification of EN779:2012 which is replaced by EN ISO 16890-1:2016, Air filters for general ventilation - Part 1: Technical specifications, requirements and classification system based upon particulate matter efficiency (ePM).

as killing bacteria and viruses but this is normally only a suitable solution for the equipment for health care facilities.

Toilet lid use instructions

If toilet seats are equipped with lids it is recommended to flush the toilets with closed lids in order to minimize the release of droplets and droplet residues from plumes in the air[xxxi,i]. It is important that water seals work all time[ii]. Therefore, organise that building occupants are instructed to use the lids.

Summary of practical measures for building services operation

1. Secure ventilation of spaces with outdoor air
2. Switch ventilation to nominal speed at least 2 hours before the building usage time and switch to lower speed 2 hours after the building usage time
3. At nights and weekends, do not switch ventilation off, but keep systems running at lower speed
4. Ensure regular airing with windows (even in mechanically ventilated buildings)
5. Keep toilet ventilation 24/7 in operation
6. Avoid open windows in toilets to assure the right direction of ventilation
7. Instruct building occupants to flush toilets with closed lid
8. Switch air handling units with recirculation to 100% outdoor air
9. Inspect heat recovery equipment to be sure that leakages are under control
10. Switch fan coils either off or operate so that fans are continuously on
11. Do not change heating, cooling and possible humidification setpoints
12. Do not plan duct cleaning for this period
13. Replace central outdoor air and extract air filters as usually, according to maintenance schedule
14. Regular filter replacement and maintenance works shall be performed with common protective measures including respiratory protection

Feedback

If you are specialist in the issues addressed in this document and you have remarks or suggestions for improvements, feel free to contact us via info@rehva.eu. Please mention 'COVID-19 interim document' as subject when you email us.

Colophon

This document was prepared by a group of REHVA volunteers, the first version in the period March 6-15th 2020. Members of the expert group are:

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Literature

This document is partly based on a literature survey, the scientific papers and other documents that were used can be found in this document: https://www.rehva.eu/fileadmin/user_upload/REHVA_Literature_COVID-19_guidance_document_ver2_20200402.pdf

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