Public Health Scotland

Guidance for the public health management of acute respiratory infections (ARI) in community, social and residential care settings

Guidance for health protection teams (HPTs)

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Overview

This guidance aims to provide health protection teams (HPT) with a clear, concise, and accessible overview of the public health approach to prevention and management of acute respiratory infections (ARI) in community, social and residential care settings.

This guidance has been developed for use in Scotland through the Scottish Health Protection Network (SHPN).

It was developed using agreed SHPN methods and is based on the UKHSA Infection prevention and control (IPC) in adult social care: acute respiratory infection (ARI) (2024). The UKHSA guidance was assessed and adapted for use in Scotland by a guidance development group (GDG).

A full method statement is detailed in the guidance development process section.

This guidance replaces the Public Health Scotland:

- COVID-19 guidance for social and residential care settings (version 2.9)
- guidance for the public health management of COVID-19 infections in the community and community settings (version 3.3).

This guidance should be used alongside the following.

Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)	• National Infection Prevention and Control Manual (NIPCM) • Care Home Infection Prevention and Control Manual (CHIPCM) • Resource for respiratory illness
Scottish Government	• Guidance on the management of public health incidents • Health and Social Care Standards (HSCS), chapter 5, paragraphs 4.16 and 5.17
Public Health Scotland	• Health protection in children and young people settings, including education

How to use this guidance

For best practice, this guidance should be used in its online form.

You can download versions for printing but please regularly check the most recent version of the guidance available online is being referred to.

This guidance is primarily non-statutory. This means that it is not a legal requirement to implement the recommendations made.

Where the guidance references a legal requirement, for example in relation to the Public Health etc. (Scotland) Act 2008 this is made clear.

The guidance does not replace or override any legislative or statutory requirements.

This national guidance should be used as the primary reference document. This will promote consistency and minimise unnecessary variation in professional practice across Scotland.

However, it does not replace individual expert judgement or local response arrangements.

Any comments or suggested improvements can be sent to the PHS Guidance Team at phs.guidance@phs.scot

Intended audience

This guidance is for health protection teams (HPTs) in Scotland.

Local services and other stakeholders may use this document for reference.

Advice for care providers on preventing and managing ARI outbreaks is available from the local health protection teams (HPTs).

Key principles in health protection

Every situation and outbreak are different.

HPTs adopt a pragmatic approach and make a risk assessment based on many factors.

HPTs' main task is protecting the public's health, and while this means reducing the risk of transmission of infectious diseases as far as possible, this must also balance other needs of those affected.

The approach is, therefore, to take the least restrictive measures that will achieve an appropriate reduction in transmission risk and mitigate its effects at the community and at individual level.

Hence, while it may be appropriate to take certain measures in a particular situation, the same measures may create other unacceptable risks in a different scenario.

This pragmatic health protection risk assessment approach also applies to isolation periods.

Therefore, while the isolation periods recommended within this guidance may not exactly match those in other documents, they aim to provide a practical approach to manage various circumstances in the specific settings that this guidance covers, considering various individual and population factors.

What the guidance covers

In scope

This guidance is for the public health management of ARI in community, social and residential care settings.

This guidance covers:

- definition on ARI, including:
  - symptoms and transmission
  - measures to prevent or mitigate the severity of infection
- testing recommendations
- public health management of those with ARI
- ARI outbreak management
- visiting arrangements in community, social and residential care settings

Settings covered

Health and social care settings is a term used throughout this document to capture the settings providing these services in Scotland.

'Service user' is used throughout this guidance as a generic term to denote a resident, patient or individual accessing services, associated with any of the settings covered within this document.

Where guidance is specific to a care home setting, the term 'resident' is used for those living there.

Settings covered by this guidance include higher and lower risk settings. Risk is also defined in terms of vulnerability of the service users, and lower risk settings may still have individual higher risk service users.

Higher risk settings include:

- care home services, registered with the Care Inspectorate – where the population residing are mainly older adults
- hospices

Lower risk settings include:

- situations where social care is provided to individuals in their own home
- community-based day services
- community-based residential settings, such as for people:
  - with mental health needs
  - with a learning disability
  - who misuse substances
- rehabilitation services
- residential children's homes
- residential respite/short break services
- services helping those experiencing homelessness
- accommodation housing asylum seekers and refugees
- sheltered housing
- supported accommodation settings
- prisons

Out of scope

This guidance does not cover:

- the management of ARI outbreaks in hospital settings, for which guidance is available in chapter 3 of the NIPCM.
- clinical management of ARI

This guidance also does not cover the public health management of respiratory infections caused by pathogens for which PHS has specific guidance, including:

- legionella
- pertussis
- streptococcus pneumoniae
- haemophilus influenzae
- avian Influenza
- Middle East respiratory syndrome (MERS)

The PHS health protection in children and young people settings, including education guidance may provide useful advice for the management of ARI in educational and early years settings.

Definition of ARI

Acute respiratory infection (ARI) is defined as the acute onset of one or more of the respiratory symptoms and/or a clinician's judgement that the illness is due to an infection of the respiratory tract.

Acute respiratory infections can be caused by several respiratory viruses and bacteria including, but not limited to:

- influenza A and B viruses
- respiratory syncytial virus (RSV)
- human metapneumovirus (hMNV)
- parainfluenza viruses
- rhinovirus
- coronaviruses (including SARS-CoV-2)
- adenoviruses
- enteroviruses
- Mycoplasma pneumoniae

In the initial stages of a case or outbreak, HPTs will often not know the causative organism(s), and will need to manage as a generic ARI (unless the organism is strongly suspected). However, once the cause of illness becomes more clear, this may enable more specific measures to be put in place

Once identified, the management of bacterial pathogens such as Streptococcus pneumoniae, Haemophilus influenzae, and Bordetella pertussis is beyond the scope of this guidance due to the differences in laboratory testing pathways and treatments.

There are links to specific guidance in the what the guidance covers section.

Transmission of ARI

ARIs can be spread through three different transmission routes:

- contact (direct and indirect)
- droplet
- aerosol

Contact transmission occurs when a pathogen is transferred:

- directly from an infected person to a susceptible individual – for example, through contaminated hands
- indirectly via surfaces or objects

Transmission of respiratory pathogens through the air can occur via droplets or aerosols expelled by the infected person.

The mode of transmission of ARIs will vary depending on the pathogen.

Infection control precautions are therefore based on limiting and avoiding transmission from contact, aerosol and droplet routes, as well as environmental cleaning.

To support understanding of current levels of circulating ARI and pathogen-specific infections in Scotland, PHS provides a dashboard on viral respiratory diseases in Scotland, updated on a weekly basis. Between October and March, PHS also provides a weekly report tracking infectious respiratory diseases, and monthly outwith this period.

Quarterly information on immunisations and vaccine-preventable diseases under surveillance in Scotland is also available in the PHS Immunisation and vaccine-preventable diseases quarterly report.

Symptoms of ARI

Common symptoms of acute respiratory infections include:

- a new continuous cough
- sneezing
- a stuffy or runny nose
- a sore throat
- headaches
- muscle aches
- breathlessness, tight chest or wheezing
- fever (temperature of 37.8°C or above)
- chills
- malaise

It can be difficult to identify the pathogen causing the ARI by symptoms alone.

It can be even more difficult among those who have a reduced ability to recognise or communicate symptoms, however non-respiratory symptoms – for example, collapse, diarrhoea, nausea, loss of appetite, vomiting – should also be noted, especially in:

- children and frail older people
- those with pre-existing conditions (such as those with cognitive impairments)
- those who are immunocompromised

It is therefore important to consider the possibility of ARI if there is a sudden deterioration in physical health or mental ability, in the absence of a known cause.

Unwell service users or staff may require a clinical review if symptoms worsen or persist for longer than expected, for example to assess if a secondary bacterial infection or other pathological process has arisen.

HPTs and other users of this guidance are reminded that in case of clinical deterioration or life-threatening symptoms, there should be no delay in contacting the GP, NHS 111 or emergency services as appropriate.

If admission to hospital is required, inform the healthcare provider about any suspected or confirmed infection prior to hospital transfer.

Testing

Each health board will have their own processes in place for microbiological testing for respiratory pathogens.

Testing is rarely needed for ARIs but may be recommended to support:

- clinical diagnosis, when advised by a healthcare professional
- those who may be eligible for pathogen-specific (i.e. influenza or SARS-CoV-2) treatment
- outbreak management in both higher and lower risk settings, following advice from HPTs or local infection prevention control teams
- respiratory infection surveillance through sentinel general practices such as Community Acute Respiratory Infection (CARI) surveillance

COVID-19 should now be managed like other ARIs (see table 1).

Therefore, the routine testing of symptomatic health and social care staff for COVID-19 is no longer indicated in line with the advance notice of changes to the Scottish Government's COVID-19 testing guidance.

Carrying out an LFD, a rapid antigen test for detecting COVID-19, when experiencing respiratory symptoms is no longer required nor recommended for most people, nor are residents of care homes and hospices routinely tested for asymptomatic COVID-19 infection upon discharge from hospital.

Care staff must ensure that test devices, swabs and extraction solutions are not damaged, broken or out of date.

Table 1: ARI testing guidance

Cohort	Symptomatic of respiratory infection (up to 5 cases, if outbreak suspected)	Asymptomatic	Asymptomatic but known contact with a person with respiratory symptoms
Higher risk settings or service users	Microbiological testing if needed or recommended by HPT	No testing required	No testing required, monitor for symptoms,
Higher risk settings or service users (admissions or transfers)	Risk assessment for relevant symptoms before admission	No testing required Risk assessment based on ARHAI respiratory questions[1]	No testing required, monitor for symptoms
Lower risk settings or service users	Follow NHS inform advice on acute respiratory infection Microbiological testing if clinically indicated	No testing required	No testing required, monitor for symptoms
Lower risk settings or service users (admissions or transfers)	Risk assessment for relevant symptoms before admission	No testing required Risk assessment based on ARHAI respiratory questions	No testing required, monitor for symptoms
All staff	Follow NHS inform advice on acute respiratory infection	No testing required	No testing required, monitor for symptoms

References

1. The ARHAI respiratory questions will help inform the clinical/care team of the respiratory status of the service user and potential associated risk before face-to-face care delivery

Prevention and mitigation of harms from ARI

The best way to reduce the spread and mitigate the harm of ARIs is to combine infection prevention control (IPC) precautions in community and health and social care settings with:

- vaccinations
- non-pharmaceutical and medical interventions
- proportionate outbreak management

The following sections address the various measures for preventing and mitigating the harms of ARI in community, social and residential settings.

Reducing transmission when symptomatic

It is recommended to stay at home or in one's place of residence and avoid contact with others when experiencing respiratory symptoms, particularly if there is a high fever or the individual feels unwell (unable to perform usual duties or activities), to help reduce transmission.

This applies equally to service users/residents, staff and visitors.

- Keeping away from vulnerable others (older people, those with general poor health, the immune-compromised) when respiratory symptoms are present is advised.
- Visits to higher risk settings, including hospitals and care homes, or to individuals identified as higher risk, are not advised.
- Returning to normal activities – for example, work, residential school, routine social events – is reasonable when fever has subsided without antipyretics and the individual feels well.
- There is no specific time limit for avoiding contact with others, although a discretionary 48 hours post-resolution of fever can be used.
- Self-isolation is also advised for people with respiratory symptoms who reside in closed settings such as older adult care homes.

Table 2: Self-isolation and avoidance of contacts: recommendations for ARI and diagnosed pathogens to reduce transmission

Pathogen	Incubation period	Infectious period	Avoid contact with others (lower risk settings)	Isolation period (higher risk settings)
ARI – unknown	N/A	N/A	48 hours after fever resolved and feels well enough to resume normal activities	48 hours after fever resolved and feels well enough to resume normal activities
SARS-CoV-2	3-6 days (range 1-14 days)	2 days prior to symptom onset and up to 10 days following symptom onset	48 hours after fever resolved and feels well enough to resume normal activities	5 days (fever resolved for 48 hours and feels well enough to resume normal activities)
Influenza (A/B)	2 days (range 1-4 days)	1 day prior to symptom onset and up to 5-7 days following symptom onset	48 hours after fever has resolved and feels well enough to resume normal activities	5 days (untreated) 3 days (treated with an antiviral) (fever should be resolved for 48 hours and feel well enough to resume normal activities)
Respiratory syncytial virus (RSV)	2-8 days	1-2 days prior to symptom onset up to 3-8 days following symptom onset Those with weakened immune systems can shed virus up to 4 weeks after cessation of symptoms	48 hours after fever has resolved and feels well enough to resume normal activities	48 hours after fever has resolved and feels well enough to resume normal activities
Human metapneumovirus (hMPV)	3-6 days	RNA detection 5 days – 2 weeks after symptom onset Infectious period unknown	48 hours after fever has resolvedand feels well enough to resume normal activities	48 hours after fever has resolved and feels well enough to resume normal activities
Human adenovirus (HAdV) (respiratory)	2-14 days	The virus is shed during the initial 2 weeks of symptoms with infectious particles able to survive on fomites for up to 2 months	48 hours after fever has resolved and feels well enough to resume normal activities For gastroenteritis by adenovirus, 48 hours after last episode of diarrhoea	48 hours after fever has resolved and feels well enough to resume normal activities For gastroenteritis by adenovirus, 48 hours after last episode of diarrhoea

Pathogen	Incubation period	Infectious period	Avoid contact with others (lower risk settings)	Isolation period (higher risk settings)
Rhinovirus	Average 2 days	A few days before symptom onset until all symptoms have resolved	48 hours after fever has resolved and feels well enough to resume normal activities	48 hours after fever has resolved and feels well enough to resume normal activities
Parainfluenza	1-7 days	12-24 hours prior to symptom onset and up to 5 days following symptom onset	48 hours after fever has resolved and feels well enough to resume normal activities	48 hours after fever has resolved and feels well enough to resume normal activities
Enterovirus D68	3-5 days	Whilst symptomatic (up to 21 days)	48 hours after fever has resolved and feels well enough to resume normal activities	48 hours after fever has resolved and feels well enough to resume normal activities
Mycoplasma pneumoniae	1-4 weeks	Whilst symptomatic	48 hours after fever has resolved and feels well enough to resume normal activities	48 hours after fever has resolved and feels well enough to resume normal activities

For more information on recommendations for testing in higher and lower risk settings, see the testing for ARI section.

Standard infection control (SICPs) and transmission-based precautions (TBPs)

The basic IPC measures that should be used in health and social care and care home settings are called Standard Infection Prevention and Control Precautions (SICPs).

SICPs are used to reduce the risk of transmission of infectious agents from known and unknown sources of infection. Health and social care settings should follow advice in the National Infection Prevention and Control Manual (NIPCM).Care home settings should follow advice in Care Home Infection Prevention and Control Manual (CHIPCM).

Other settings within the scope of this guidance who do not fall under a care home or health and social care definition should follow the general prevention advice within this section.

Additionally, transmission-based precautions (TBPs) – in other words, enhanced precautions – should be applied when caring for individuals who have suspected or known infection.

General prevention measures

Hand washing and respiratory hygiene

Ensuring effective hand hygiene, respiratory and cough hygiene assists everyone in reducing onwards transmission.

- Covering mouth and nose with disposable tissues reduces onward transmission of viruses and bacteria when coughing or sneezing. Tissues should be placed in a bin immediately and hands washed. When tissues are not available, coughing or sneezing into the crook of the elbow is advised, and not into hands.
- Washing hands removes viruses and other micro-organisms, making infection less likely when people touch their faces. Using soap (preferably liquid soap) and warm water is the most effective way to clean hands, especially if they are visibly dirty. Hands should be thoroughly dried after washing. This should be done regularly throughout the day, especially before meals and after toileting. Hand sanitiser should only be used

when soap and water are not available. It is important to note that the use of hand sanitiser is not effective against gastrointestinal viruses (e.g.,norovirus).
- Individuals who are unable to wash their hands independently, such as young children or older adults, should be supported to do so.

Personal protective equipment (PPE)

PPE is used to provide the wearer with protection against risk of infection, associated with the tasks they are undertaking. PPE can range from use of gloves, aprons, face masks and eye protection, for example.

Continuous use of face masks in social care settings, including care homes, is no longer required nor advised routinely but may be implemented as a measure to reduce transmission in an outbreak or when there are unusually high levels of respiratory infection circulating.

PPE such as FRSM, apron and gloves should be used when providing support or care to a symptomatic service user, in an outbreak situation or on the advice of local HPT or IPCT.

Further advice is available on respiratory protective equipment (RPE) for exceptional circumstances, e.g. novel viruses or aerosol-generating procedures (NIPCM).

Staff may require PPE training, which is the responsibility of the employer to provide.

Additional measures may need to be introduced when there are localised clusters or outbreaks. The HPT will advise in these instances.

Face mask versus face covering explained

Face mask	The use of the term face mask means surgical or other medical grade masks. For example, fluid resistant surgical face masks (FRSM) used in certain health and social care settings.
Face covering	The use of the term face covering means something that is made from cloth or other textiles that covers the mouth and nose, through which you can breathe. For example, a scarf.

Safe management of the environment

Clean surfaces should be maintained in individual bedrooms/en-suites and communal areas for residents and staff. home environment and workplaces. Settings covered in this guidance should carry out regular cleaning of the environment with particular attention to frequently touched surfaces and shared areas, such as light switches, work surfaces and electronic devices.

Ventilation

Allowing fresh air into indoor environments, especially if someone with ARI is present is advised.

This can be done by:

- opening a door or window even for a few minutes at a time, periodically, maintaining comfortable temperature levels
- using trickle vents and grills, for a constant small flow of air

During periods of high temperatures, fans may be used to improve thermal comfort in the setting, when turning off heating and opening windows is not sufficient. A risk assessment approach should be taken when using fans during an ARI outbreak.

The UKHSA COVID-19 ventilation of indoor spaces guidance advises to keep room temperature to at least 18ºC as temperatures below this can affect health. This is especially applicable to those who:

- are 65 years or older
- have a long-term health condition

Ventilation in the workplace guidance is available from Health and Safety Executive (HSE).

Ensuring wellbeing whilst isolating or staying away from others

A person-centred human rights approach should be taken wherever possible when managing infectious disease. When cases or outbreaks are identified, an appropriate balance for the case and population affected between ensuring general well-being and mitigating the risks of infectious transmission and severity of disease is aimed for.

Providers should ensure the wellbeing of residents who are being supported to stay away from others. Symptomatic residents:

- Should be encouraged to wash their hands, wear a face mask when walking through communal areas, and be supported to stay away from other residents while accessing the services
- Should be supported to safely access the toilet and shower rooms outside of their room when en-suite facilities are not available
- Should also be supported to go into outdoor spaces within the grounds of accommodation through a route where they will not be in contact with other residents
- Visiting should continue to be supported for those with symptoms or confirmed ARI. See section 'When a resident is symptomatic or has confirmed ARI (higher risk settings)'.
- Services should always give consideration as to how isolation may impact people's wellbeing and provide support during this period.

Further advice

Further advice on preventing infection is available from NHS Inform. This information is in context of COVID-19 but the general advice on staying at home and preventing the spread of infection is applicable to all ARIs.

For further guidance on living with ARIs, refer to UKHSA living safely with respiratory infections, including COVID-19.

Mitigation of potential harms from ARIs

Vaccination

Vaccinations against certain ARIs for selected eligible populations are available in Scotland.

Influenza, COVID-19 and RSV vaccines are effective at building immunity against infection in most people. Though infection can still occur despite vaccination, the risk of suffering from severe illness, hospitalisation or death is reduced.

The Joint Committee for Vaccines and Immunisation (JCVI) advises UK health departments on immunisations for the prevention of infections and/or disease following due consideration of the evidence on the burden of disease, and on vaccine safety and efficacy.

Individuals eligible for vaccination will be contacted by the NHS as per JCVI recommendations. The Green Book provides up to date information on vaccines, effectiveness, schedule, and other relevant information, with chapters specific to COVID-19, influenza, and RSV.

The link for NHS Scotland winter vaccine programme has information of eligibility for influenza, childhood influenza, and coronavirus vaccines as well as access to the booking portal. Information on the RSV vaccination for older adults and during pregnancy are also available from NHS Inform.

Every opportunity should be taken to update individuals with vaccinations for which they are eligible. Services should aim to vaccinate service users before admission to a residential setting, or as soon as feasible after admission. Sometimes vaccination may not be possible before unplanned admissions or due to medical exemption. The need for vaccination should not delay admission.

All frontline health and social care workers are eligible for the free flu and COVID-19 vaccines, while all NHS staff are eligible for the flu vaccine.

Antiviral treatments and prophylaxis

Some service users who test positive for influenza or COVID-19 may be eligible for antiviral treatments and should be supported to access these as quickly as possible.

Influenza treatment and prophylaxis

Antivirals for the treatment and prevention of influenza work best when people start them within 2 days of becoming unwell or being in close contact with a person with influenza.

Treatment with influenza antivirals in care homes may be recommended by a clinician for residents with confirmed or suspected influenza, particularly seasonal flu virus is circulating. Less frequently, the local HPT may consider recommending influenza antiviral medicine prophylaxis for contacts of confirmed or suspected cases in a higher risk setting.

Factors that might support such a recommendation include:

- a high number of flu cases in the setting (high attack rate),
- higher levels of serious illness or poor outcome among residents,
- low influenza vaccine uptake in the setting,
- or if the vaccine does not match well to the circulating flu strain in a given season.

Information for clinicians on individual patient eligibility for influenza antiviral treatment and prophylaxis is available at Influenza: treatment and prophylaxis using anti-viral agents.

When influenza activity levels breach the epidemic threshold each winter, a letter from the Chief Medical Officer (CMO) regarding the use of antivirals for seasonal influenza is circulated.

Further details on the use of antiviral agents in Scotland are explained in the PHS external guidance addendum: for UKHSA 'Guidance on the use of antiviral agents for the treatment and prophylaxis of seasonal influenza'.

COVID-19 treatment

People who are at higher risk of severe outcomes from COVID-19 may be eligible for COVID-19 treatments if they become unwell. See NHS inform for more information.

Staff and service preparedness in community settings

The information in this section is applicable to all staff working in both lower and higher risk settings.

Measures for staff

Staff who have contact with a symptomatic case

In discussion with their line manager, staff who come into contact with an ARI case do not need to stay at home unless they develop a fever or feel unwell.

Whether a case arises in a lower or higher risk setting, staff need to be vigilant to ARI symptoms at all times. This is particularly important during the incubation period after contact with a suspected or confirmed case or during an outbreak.

If symptoms develop, staff must follow NHS inform stay at home guidance for the general public or their employer's occupational health protocols (if this is in place).

Their return to place of work will need to be risk assessed with the service manager (or occupational health service, if this is accessible).

The service manager should check appropriate infection prevention and control measures are in place for staff, confirming that the risk of transmission has been minimised in the workplace.

Risk assessment at work

Where a service provides care for people who are severely immunosuppressed, the service manager should risk assess the placement of staff who report being contacts of a case or are symptomatic themselves (in which case, refer to the following section on staff who become symptomatic).

Risk assessment may result in a temporary change to location or tasks of work.

This applies regardless of whether staff have had contact with a symptomatic case at work or at home.

Staff who become symptomatic

If symptoms develop at work, staff should put on a fluid-resistant (type IIR) surgical mask (FRSM) and discuss continuation of work with their manager.

Through risk assessment that considers the service user and staff member's needs, they may need to change duties or cease work before the end of their shift.

Services are advised to have processes in place to support such eventualities, including the need to document decisions informed by Occupational Health advice, where appropriate.

Staff members need to be aware of ARI symptoms and follow advice on managing symptoms of a respiratory infection.

Staff members should only test for ARI if they are eligible for COVID-19 treatments, if they have been advised by a clinician as part of their own medical care, or if they have been advised to do so by a HPT.

Health and social care staff should adhere to the NHS inform stay at home guidance on managing symptoms of a respiratory infection and any local service occupational health policies.

Staff returning to work

Staff can return to work when they are feeling well and are able to resume normal activities.

It is advised they should not have had a high temperature for at least 48 hours without use of antipyretics.

Staff with persistent symptoms should be risk assessed by their line manager when returning to work. This would be part of a return-to-work interview, as per usual processes.

Particular consideration should be given to the placement of staff working with individuals who are severely immunocompromised.

The local HPT can support with complex risk assessments.

Service preparedness

Settings should plan ahead to prepare for extra demands on staffing needs due to outbreaks or staff absence. This is known as resilience planning.

Resilience planning

It should include:

- encouraging a high uptake of COVID-19, annual influenza and other occupational vaccines in all staff, when this is offered
- appropriate training on infection prevention and control, especially for new or agency workers
- a regular review of resources and supplies, including PPE, needed to support service users when they are unwell or in self-isolation
- having a supply of PCR kits available and know local testing pathways
- resource to support named visiting during outbreaks
- time and resource required - see the Care Home IPC checklist for respiratory illness in the Care Home Infection Prevention and Control (IPC) Resource for Respiratory Illness – including:
    - PPE use
    - increased cleaning
    - staff cohorting
    - training updates
    - guidance review

Resilience planning is particularly important for small departments where even a few staff absences could have significant impacts on service provision and care for service users.

New staff or agency staff

Service providers need to ensure that new and agency staff are adhering to processes applicable to service staff, including training and advised vaccination.

A risk assessment approach should be taken when using staff from other care homes, residential settings or healthcare services, to replace care home staff as part of resilience planning. Sharing staff between services during outbreaks is not advised.

A documented risk assessment of the use of agency staff can support good governance.

Managing service users with symptoms of ARI

Most people affected by ARI can be managed at home/residence with rest, hydration, and simple antipyretic medication.

If one service user is identified with respiratory symptoms, **staff should assess if there are others with symptoms and ensure that all IPC precautions are in place.**

The local HPT should be contacted if two or more symptomatic cases arise within a specified time-period (5 days, indicative, unless the organism is known) within a higher risk setting and meet the definition of an ARI outbreak.

Refer to the outbreak management section for more information.

If a service user has symptoms of ARI

For recommendations on isolation periods for ARIs in higher and lower risk settings, refer to table 2 in the section on reducing transmission when symptomatic.

Higher risk setting

In higher risk settings, residents with symptoms of ARI, should be supported to stay away from others to protect those who may be at risk of severe ARI outcomes.

Residents with symptoms of ARI should be tested where clinically indicated to confirm a pathogen.

Where no pathogen is confirmed through testing, the resident should be supported to stay away from others for 48 hours after fever has resolved and they feel well enough to resume normal activities.

Lower risk setting

Service users based in lower risk settings and who have symptoms of ARI, a fever, or do not feel well enough to carry out their usual activities should:

- be supported to stay at home or residence
- follow NHS inform guidance to manage their symptoms
- avoid contact with other people until they feel well again, and their fever has resolved

Testing may be undertaken if clinically indicated, such as for service users with additional risk factors or co-morbidities.

Service users who are unwell may require a clinical review if symptoms worsen or persist for longer than expected.

If a service user tests positive for ARI

Providers should continue to follow the guidance in section on prevention and mitigation of harm from ARIs to ensure IPC precautions are adopted and implemented.

Outbreak management

Local HPTs lead on the management of ARI outbreaks in the community, when indicated, including care homes and other closed settings, according to their statutory duties under the Public Health Etc. (Scotland) Act (2008).

They make decisions on outbreak control using a population-based risk assessment approach in discussion with the service manager.

Sometimes an incident management team (IMT) or problem assessment group (PAG) chaired by the local HPT is constituted to support this approach.

To foster good communication lines with those affected when an outbreak is declared in a service, service users and their next of kin or relatives should be informed.

Consideration of a brief written communication to the service should be made, outlining the situation as soon as possible from the outbreak declaration.

Service management can then continue with updates thereafter, with support from the HPT if needed.

This section considers the:

- circumstances of the outbreak
- setting itself
- individuals involved

Definition of an ARI outbreak

An ARI outbreak can be defined as two or more linked cases with the same infectious agent – or where there are a higher-than-expected number of cases – associated with the same setting, over a specified time-period.

Pragmatically, this may be a 5-day window from case onset, noting that incubation and infectious periods can vary between respiratory infectious pathogens. For example, SARS-CoV-2 has a maximal incubation period of 14 days.

One case may be sufficient to declare an outbreak if it is an unexpected or rare pathogen, such as Middle East Respiratory Syndrome (MERS) or legionella.

When determining an outbreak, HPTs should consider whether there is:

- an epidemiological link by person and place as part of their assessment
- a greater than expected rate of infection when compared to the usual background rate

ARI outbreak management should follow well-established public health risk assessment principles and practice.

HPTs do not need to identify and manage outbreaks in all social and residential care settings. It is advised that lower risk settings should aim to deal with outbreaks independently and do not need to routinely report these to HPTs. HPTs can be contacted if support for a challenging situation is needed.

Lower risk setting

Avoid other people

Service users with symptoms of ARI should stay at home/residence (or go home if they are at a day facility) and avoid contact with other people until their fever has resolved and they no longer feel unwell.

There is no specific time limit for avoiding contact with others. 48 hours after fever resolved can be used and is discretionary.

Inform contacts

If possible, service users with symptoms of ARI should inform others with whom they have been in contact in the previous 48 hours, including household members, that they have had respiratory symptoms, particularly if contacts are in higher risk groups.

This ensures that contacts are vigilant of respiratory symptoms that may develop

Be risk assessed

Service users with symptoms of ARI should also be risk assessed if transfer to another service or to hospital is needed during the period of self-isolation.

This should be performed jointly with the receiving service.

The transport service should also be informed

Higher risk setting

In higher risk settings, such as older adult care homes, 'stay at home' advice also applies.

Managing self-isolation (see table 2 for periods of self-isolation) in such settings means that:

- residents are advised to:
  - remain in their single room with en-suite facilities or dedicated toilet
  - keep room door closed, where possible
  - avoid using shared spaces within the facility or unit cohorting, where possible
  - maintain personal toiletries
- staff should:
  - arrange dedicated toilet facilities or a commode if en-suite accommodation is not available – decontaminate these immediately after use
  - consider staff cohorting, where specific staff are assigned to residents who are self-isolating
  - consider a rota for showering and bathing, placing the symptomatic service user last
  - provide meals for the individual to eat within their room
  - carry out all necessary care within the service user's room, where possible
  - communication with key relatives (and other regular visitors, when relevant) should be in place to inform them of changes in management of their loved ones – this includes when visiting arrangements are altered

Notification of outbreaks

Some settings, such as older adult care homes, have obligations to report clusters or outbreaks to other agencies, for example:

- Care Inspectorate
- evironmental health departments
- Health and Safety Executive
- health protection team

Guidance outlined in the remainder of this section potentially applies to all community settings, but more usually used for those managed by HPTs in higher risk settings, such as older adult care homes.

Outbreak risk assessment and management

Identifying linked cases

The assessment of linked resident cases when considering any potential outbreak should take time and place into account.

Linked cases should arise within a specified time-period.

Pragmatically this may be 5-days from case onset but with consideration of incubation and infectious period of the identified pathogen.

The assessment of linked cases when considering any potential outbreak should include:

- individuals who are or have been present in the location where a case has been identified
- individuals who have been transferred from the setting to hospital, or elsewhere
- those who have since died
- 2 or more cases of the same pathogen
- consider whether multiple pathogens are circulating

An initial risk assessment should be undertaken by the service manager without delay and if there is evidence of transmission between staff and/or service users, or uncertainty in this, the local HPT should be contacted for advice.

When investigating ARI transmission in a setting and implementing mitigation measures, staff cases should be treated separately if no links are found.

For example, if staff were exposed at home whilst off duty or on leave and haven't yet returned to work since showing symptoms, then they should not be connected to workplace transmission.

Testing for cases

Generally, testing is not indicated in lower risk settings, where stay at home advice should be actioned.

When a cluster of symptomatic cases arises in a higher risk setting, it is good practice to submit samples for up to five symptomatic residents to confirm the pathogen.

PCR testing should be used. Requests for additional testing should be discussed with the local laboratory in advance of sending samples.

Additional cases matching the outbreak case definition do not all need to be tested once a pathogen is identified.

This may change if multiple pathogens are circulating and is at discretion of the local HPT.

The HPT has autonomy to deviate from the guidance according to local circumstances and to the risk assessment.

Mass testing

Mass testing is unlikely to be justifiable in outbreak situations as it may have unintended consequences of likely greater harm than benefit.

For example, prolonged periods of unnecessary self-isolation and false positive or negative results that may be challenging to interpret in light of symptoms.

Any mass testing should be based on a risk assessment by the HPT/IMT.

Declaring an outbreak

Declaring an outbreak is the responsibility of the HPT.

See the definition of an ARI outbreak.

An IMT may be convened and led by the local HPT. If not, support will be managed by the HPT with the settings manager, when indicated.

In some health boards the local IPCT supports the local HPT and service on infection control interventions.

Initial mitigation measures

If a service in higher risk setting identifies a cluster of symptomatic cases, the service provider needs to:

- alert the local HPT who will support a risk assessment and investigate whether an outbreak is occurring
    - the level of response to an outbreak from the HPT will be based on the HPT risk assessment
- undertake a rapid internal review of the setting's risk assessment and prevention measures
    - consider any improvements to their implementation as a priority

Where indicated, the HPT may ask to review the services' workplace risk assessment or other outbreak management plan.

These steps should be undertaken collaboratively with the setting and be used to develop an individualised action plan for outbreak management.

The HPT should engage and support settings to manage the outbreak proportionate to their assessment of the risk to public health if approached for advice.

HPT may make the decision to engage in the handling of individual cases, clusters or outbreaks at their discretion.

Outbreak control measures

A number of outbreak management measures are available for consideration, as advised by the HPT.

Not all measures will be needed but should be agreed between the HPT and service manager initially and reviewed regularly during the outbreak.

These may include, but are not limited to:

- regular monitoring of residents' symptoms
- isolation of cases for service users who are symptomatic or confirmed ARI cases
- enhanced cleaning of the premises
- change from routine to named person visiting (and exceptionally, moving to essential visiting)
- cohorting of residents and/or staff, including designation of a unit for cohorting
- temporary restriction of professional visitors
- temporary re-introduction of face masks/coverings
- temporary reintroduction of physical distancing
- temporary closure of daytime services
- additional training for the appropriate use of PPE
- possible use of mass prophylaxis in the case of an influenza outbreak

Some residents may find restrictions on their movements difficult to follow during an outbreak, for example, residents who walk with purpose.

They often need increased support during an outbreak.

Any restrictive measures put in place during an outbreak, such as restrictions to visiting, should be reviewed regularly by local HPT and stepped down at the earliest opportunity, when it is safe to do so based on a risk assessment approach.

Staff shortages

It is expected that most outbreak situations will be managed via standard working practices in place in each setting for sickness and absence at work.

However, staff shortages can quickly become an issue during an outbreak due to the size and nature of some services.

Management teams should complete their resilience planning in advance for this eventuality.

Visiting arrangements in outbreaks

See the sections for visiting arrangements in residential care settings:

- named person initiative during an outbreak (higher risk settings)
- supporting essential visiting (outbreak)

Using communal spaces

Communal areas can be kept open for use by service users who are not symptomatic of ARI – this is the default position during an outbreak if it can be arranged by staff.

Sometimes it is possible to manage selected areas of a residential facility as a separate unit or units, with no shared activities or staff, known as 'unit cohorting'.

Unaffected units can continue with normal arrangements, with increased symptom vigilance in their service users and staff.

Communal areas may need to be more closely supervised to ensure symptomatic or confirmed cases do not mix with others.

If outbreak measures prove particularly challenging to implement or staffing levels are critically low, communal areas may be temporarily out of use.

They should be reopened as soon as practical.

Transfers and admissions

Transfers and admissions of service users in and out of the setting during an outbreak must be risk assessed.

Factors to consider include:

- service user's respiratory assessment
- size of the outbreak
- spread within the setting
- units which are affected
- physical layout of the building
- vaccination status of the individual and coverage at the setting

Advise any receiving service, for example a hospital ward or ambulance or residential care facility, of the IPC precautions needed for each service user they support in that transfer of care.

Declaring an outbreak over

For a HPT to declare an outbreak over, there should be no new linked symptomatic or confirmed cases for a minimum period of two incubation periods from the last possible exposure to a case.

Refer to table 2 for further information on incubation periods.

Where appropriate, an outbreak can be declared over, well after all outbreak measures have ceased.

Until that time vigilance for cases is advised.

The HPT should also consider whether:

- existing cases have been isolated or cohorted effectively
- appropriate IPC precautions are in place
- sufficient staff to enable the setting to operate safely using PPE appropriately are in place

Visiting arrangements

Contact with loved ones is fundamental to care home residents' health and wellbeing and visiting should be supported.

In support of this, the Health and Social Care Standards (HSCS) outline that care home visits to residents and their visits outside of the home should be facilitated unless there are exceptional circumstances.

Appropriate precautions should be implemented to ensure that visits can occur safely, when needed.

Older adult care homes remain vulnerable settings due to their closed nature, communal living and the susceptibility of the resident population to infectious disease.

This advice does not apply to people receiving care in a domestic premises.

Supporting visiting

HPTs can be contacted to provide support to service managers on visiting arrangements, particularly during outbreaks.

Local health and social partnership oversight teams (working alongside local HPTs, IPCTs and service managers) have a role in supporting care homes or residential settings to implement visiting effectively.

The Care Inspectorate provides useful information for service managers and the public for clarification on visiting.

The public can contact the Care Inspectorate directly if they have specific concerns.

Vaccination is strongly encouraged for all eligible visitors but it is not obligatory for visits.

Routine visiting

Service users will have different needs or preferences for visiting.

These should be supported to help service users maintain their health and wellbeing.

The manager of residential premises ensures that routine visiting processes are appropriate for the setting in agreement with their service users and those supporting them.

Each service user should have visiting needs and preferences included in their individualised care plan, balanced against the needs of everyone in the setting, for example, when an outbreak is declared.

It is the responsibility of service managers and care home staff to communicate short-term changes to visiting to service users and their families.

There are no public health limits on length or frequency of visits nor number of visitors during routine visiting.

Community group visits

When community group visits are arranged, crowding should be avoided and assessments for visiting should consider the built environment of the setting.

If a singing or musical group is performing, distancing should be part of the risk assessment due to the nature of the activity (1 to 2 metres is advised during performance).

Visitors in outbreaks

At any time, regardless of a setting's outbreak status, visitors should not enter the care home if they are feeling unwell.

If visitors have symptoms of ARI, they should follow NHS inform advice.

Visitors should be informed of any ongoing outbreaks and current restrictions in place, allowing them to assess the risks and decide whether to proceed with their visit or postpone.

It is also important that visitors follow the IPC processes put in place by the service at all times, such as practising hand hygiene and follow the PPE recommendations from staff.

Additional requirements for face masks may be in place during a confirmed outbreak of ARI. This should be based on local assessments, considering any distress caused to residents or barriers to communication from the use of PPE.

If visitors are being asked to wear face masks, children under the age of 11 who are visiting may choose whether to wear a face mask. Face masks for children under the age of 3 are not recommended. Other IPC measures such as hand hygiene should be followed by children too.

IPC support and advice should be offered to those providing direct care to a service user including FRSM and eye protection where required.

Health, social care and other professionals may need to visit residents within care homes to provide services. Visiting professionals should follow staff recommendations for symptom control and for PPE use as per the CH IPCM.

The ARHAI respiratory symptom screening questions can be used to check for wider symptoms before interaction with service users.

When a resident is symptomatic or has confirmed ARI (higher risk settings)

Providers should ensure the wellbeing of residents who are being supported to stay in their room, away from others

Residents with symptoms of ARI should still be able to receive visitors with appropriate IPC precautions.

The local HPT can support a risk assessment for this, if needed, in complex situations.

Named person visiting during an outbreak (higher risk settings)

Use of the named person initiative

During an infectious disease outbreak, control measures may involve limiting the number of people entering and leaving a care home based on a health protection risk assessment.

Visiting should only be restricted in exceptional circumstances, where it poses an unmitigable risk to the health or wellbeing of the community of residents.

When the specific circumstances of an outbreak require this, any advice on reducing visiting should always be time limited, proportionate to each specific outbreak and using a risk assessment approach.

When a residential (higher-risk) premises is affected by circulation of an infectious organism amongst residents and/or staff, routine visiting may be temporarily suspended by the local HPT in order to facilitate quick investigation and early resolution of the transmission risk to the population in that setting.

HPTs will carry out a risk assessment and if it is felt 'named person' visiting is needed to control an outbreak.

- One of up to three named persons during an ARI outbreak can continue to visit per day, thus minimising periods of isolation from their loved ones.
- Two named persons can visit at one time if support is needed by one of them, for example, an elderly spouse.
- Exceptions remain at the discretion of the care home or residential setting and/or the HPT.

Residents have different needs and preferences for visiting. Each resident's needs and preferences for visiting should be included in their care plan from the outset of admission to the service.

It should be flexible enough to accommodate changes at short notice in agreement between setting management and the resident, and when relevant, their relatives/guardians. For example, some residents may wish to not receive any visitors during an outbreak, and this should be respected.

This person-centred approach should also be considered for visiting arrangements during any outbreaks (not solely ARIs) to support the health and wellbeing of residents as much as possible as long as it does not interfere with effective outbreak management. This is at the discretion of the HPT supporting management of the outbreak.

Staff will advise on whether the visit can take place in communal areas, or if it must be in the resident’s own room.

Having named persons visiting during an outbreak carries a degree of risk for the visitor as well as the resident, as they may themselves be vulnerable to infection or not vaccinated.

Named persons should be made aware and understand the exposure risks to themselves when visiting during an outbreak.

If the named person is unavailable

If any of the named persons cannot visit, for example, if they are self-isolating, on holiday, or ill, the service manager can facilitate an alternative individual to act as the named person and should be able to do so at short notice.

Helping with care

Care staff have a professional duty of care to the people they care for and this needs to consider the resident's wishes.

Named persons may, with agreement of the resident (or representative, including those with legal responsibilities) and the care home or residential setting staff, provide day-to-day care to support resident’s health and wellbeing. It could include encouragement to eat and drink and other forms of care. This is complementary to the care from staff. For further information, refer to the Health and Social Care Standards (HSCS).

Communal areas

Residents who are neither symptomatic nor confirmed ARI cases and their named person may continue to use communal areas if outbreak measures have been confined to selected areas of the facility, (unit cohorting is in place).

Possible or confirmed cases of ARI should not use communal areas, unless unit cohorting is in place.

This is to ensure that those individuals identified as, or working with cases avoid mixing with individuals who are not affected.

Staying connected

Staff have an important role in assisting service users to stay connected with their loved ones, if the visitor themselves have or may have an infectious disease or if the named person initiative is active. This can be particularly important during an outbreak, when visiting arrangements can change at short notice.

In addition to visiting in person, digital or other methods of communication can be considered. For example, using technology to make video-calls, phone calls and send messages or visits across a window.

Supporting essential visiting (outbreak)

The named person initiative is the default visiting process during care home outbreaks when HPTs risk assessment deems a restriction to visiting is required.

In extreme circumstances, however, the HPT may risk assess that it is necessary to move from ‘named person’ to only ‘essential’ visiting for a few days.

In such circumstances, decisions to implement essential visiting are often made through a PAG or IMT. Due to the potential impact on people's wellbeing, these additional restrictions should, wherever possible, be reviewed by HPT daily and stepped down at the earliest opportunity.

This is a more restricted form of visiting, where the named person initiative no longer applies. It is used rarely on its own. Essential visiting should always be supported.

Moving to essential visiting can occur if there is uncertainty in the effectiveness of outbreak management or serious concerns are identified and effective outbreak management is at risk.

Examples of circumstances that could lead to this include:

- inadequate PPE supplies
- serious concerns with staffing levels
- low visitor compliance with IPC advice
- higher levels of severe illness and poor outcomes than would be expected
- critical service concerns reported by the Care Inspectorate

Essential visits need to be agreed between the service user/resident, the visitor and service manager.

The service manager should use a risk assessment approach to these visits and can seek support from local HPT in complex situations.

The main reasons qualifying for essential visiting are:

- end-of-life visits supporting the process of dying
- supporting those experiencing stress or distress

Essential visiting for end-of-life

Visitor numbers for essential visits for residents receiving end-of-life care should not be limited.

There is a general understanding that the end-of-life phase for people can vary from months to hours and can be difficult to define. Essential visiting can be arranged when the individual has entered the process of dying, and there is a high likelihood of death over the next few hours or days.

Any challenging situations can be discussed with the local health protection team.

Essential visiting to support those experiencing stress or distress

If it is anticipated that even a few days without visiting would have a significant negative impact on the resident's physical, emotional, or psychological wellbeing causing distress, this can be recorded in their care plan as a likely reason for visits by one person to continue when essential visiting is in place.

Staff are encouraged to ensure care plans are current and reflect the preferences and needs of service users, as these can change.

At the time of an outbreak, further person-centred assessment of those service users who may require essential visitors may be needed, even if this has not been previously recorded.

Distressing situations can arise for some residents when a visitor misses even one visit.

Examples of conditions making a resident more at risk of being distressed with even a short absence may include:

- a mental health issue
- a learning disability
- dementia
- an unexpected upset

This visitor may be referred to as an ‘essential contact person’, for this purpose.

Settings should risk assess such situations on a case-by-case basis.

Guidance development process

This guidance was developed using agreed SHPN method to adapt the UKHSA Infection prevention and control (IPC) in adult social care: acute respiratory infection (ARI) (2024) to the Scottish context.

Given that the scope of this guidance aimed to be broader than that from UKHSA, key sections of the PHS publications 'COVID-19 guidance for social and residential care settings' (2024, version 2.9) and 'Guidance for the public health management of COVID-19 infections in the community and community settings' (2024, version 3.3) were also considered and updated, to address circumstances and scenarios that required further recommendations on good practice.

Note that SHPN and PHS method to produce guidance for health protection has been reviewed and will be available shortly.

Guidance Development Group

A multidisciplinary Guidance Development Group (GDG) was convened to produce this guidance.

The GDG had representation from:

- ARHAI Scotland
- NHS health protection teams
- NHS infection prevention control teams
- Public Health Scotland
- Scottish Microbiology and Virology Network (SMVN)
- Care Inspectorate
- Scottish Government

Each GDG member returned a conflict-of-interest (COI) form. No competing interests were declared by GDG members.

The chairing of the GDG was shared between a PHS consultant and an NHS health board consultant of public health medicine.

A core team was convened to coordinate and drive the various stages of the production of this guidance, with participation of the GDG co-chairs, a health protection nurse from PHS and PHS healthcare scientists.

Development Method

Earlier this year (2024), it was acknowledged that there was insufficient and consistent national guidance in Scotland for influenza, RSV, and other respiratory pathogens, since an increase of infections from these pathogens has been observed in the post-pandemic era.

The need to create guidance for Scotland to cover this topic was identified by the PHS Respiratory Team and the SHPN Guidance Group as a priority for this winter (2024-2025).

Aware of the urgent need of this guidance, the topic proposals leading its development made the decision to adopt a rapid process to shorten the development timeframes.

Two co-chairs were identified from PHS and from health protection teams to lead the production of this guidance, and a core team was also convened to coordinate the work of this project.

A multidisciplinary team with relevant expertise in health protection and key stakeholders was recruited to form a guidance development group (GDG).

In line with the PHS and SHPN method to produce guidance for health protection, the GDG identified the essential steps required to adapt the UKHSA guidance for Scotland and complement this with an update of key recommendations captured in the recently approved PHS guidance (June 2024) for the management of COVID-19 in the community and residential settings.

This set of documents were considered the core documents in the development process of this guidance.

The ARHAI National Prevention and Infection Control Manual (NPICM) was also widely considered in the production of this guidance.

An appraisal of the UKHSA guidance was carried out using the AGREE II instrument.

The outcome of this appraisal served the adaptation process by identifying the areas where further intelligence gathering was required to minimise the impact that shortening the development timeframes would have on the validity and the credibility of the guidance produced rapidly.

The topic proposers identified the key issues which required to be addressed in the guidance and the scope was focused on those that needed to be addressed urgently.

Key questions were identified by the GDG and a review of how they were addressed in the UKHSA guidance for ARI and in the 2024 PHS guidance for COVID-19 (used as core documents), was carried out.

It was agreed that a review of the full evidence base was not required.

An intelligence gathering exercise to capture current international guidance on this area of practice, and a rapid review of scientific evidence were also carried out to cover only those areas not fully addressed by the core documents. These were in relation to incubation periods and recommended isolation periods in higher risk settings for various pathogens included in the guidance.

Expert opinion was sought during GDG meetings, one-to-one meetings with key experts and via email. Agreement on the final recommendations was achieved through informal consensus.

Based on the evidence supporting the core documents from which this guidance is based, all recommendations are good practice recommendations, as they are primarily based on expert opinion.

Consultation

The guidance was circulated for consultation with a wide range of stakeholders.

The consultation took place in November 2024 and was open for approximately two weeks.

The consultation responses were reviewed by the core team and the guidance was updated accordingly and reviewed again by the GDG.

Approval and review

This guidance has been approved by the SHPN and PHS.

In line with the SHPN method this guidance will be reviewed in Autumn 2025. Current recommendations will be updated should key documents supporting this guidance or new evidence become available.

Feedback on this guidance can be shared with phs.guidance@phs.scot

Abbreviations

ARHAI	Antimicrobial Resistance and Healthcare Associated Infection Scotland
ARI	acute respiratory infection
CHIPCM	Care Home Infection Prevention and Control Manual
FFP	face filtering piece
FRSM	fluid-resistant surgical masks
HAdVs	human adenovirus
hMNV	human metapneumovirus
HPT	health protection team
HSCS	Health and Social Care Standards
HSCW	health and social care worker
HSE	Health and Safety Executive
ILI	influenza-like illness
IMT	incident management team
IPC	infection prevention and control
IPCT	infection prevention and control team
JVCI	Joint Committee on Vaccination and Immunisation
LFD	lateral flow device
MERS	Middle East respiratory syndrome
NIPCM	National Infection Prevention and Control Manual
PHS	Public Health Scotland
PPE	personal protective equipment
RPE	respiratory protective equipment
RSV	respiratory syncytial virus
SHPN	Scottish Health Protection Network
SICPs	standard infection control precautions
TPBs	transmission-based precautions

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