COVID-19: Information and Guidance for Care Home Settings (Adults and Older People)

Version 2.5

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Version history

An archive of all previously published versions of this guidance and supporting resources that relate to COVID-19 is available. This includes resources that have been retired from the website because they have been superseded or are no longer required. A complete summary of changes up to version 2.4 of this guidance is available in the **archive**.

Version	Date	Summary of changes
V2.5	17/12/21	Reference and guidance regarding 90-day testing window revised. Restructuring of sections to improve document flow All references to the Scottish COVID-19 Care Home IPC addendum have been replaced with the new ARHAI Scotland Winter (21/22) Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum References to 'suspected' cases have been changed to 'possible' or 'probable' cases to align with PHS and ARHAI guidance Amendments throughout the guidance based on Scottish Government letter on minimising the risk over winter and updated protective measures for Omicron variant 1.2 Spread of COVID-19: information updated and new sources of information added (Reference list included after Appendices section) 2.1 Test and Protect: advice updated to reflect that Test and Protect can advise in specific circumstances that self-isolation is completed despite an individual meeting close contact exemption criteria. 2.2 Physical distancing: advice updated for outdoors in the care home grounds 2.3 Ventilation in the care home: advice updated 2.6 Vaccination programme: addition of booster vaccine information and recommendation of vaccine during pregnancy 2.7 Infection Prevention and Control: section updated to reflect publication of Winter (21/22) Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum 3.1 Outbreak management in the care home: clarifications regarding whole home testing added 7.1 Admissions of COVID-19 recovered residents from hospital: advice updated for residents who are considered fit for discharge. 7.2 Admissions of non-COVID residents from hospital: advice updated for residents who are considered fit for discharge 7.4 Residents who temporarily leave the care home: advice updated

Version	Date	Summary of changes
		7.5 Admissions to residential respite care facilities for adults: physical distancing advice added. 8.1 Visiting professionals to the care home: advice updated 8.2 Enabling staff to follow key measures: note of caution of included regarding staff socialising out of the workplace and additional considerations to reduce risks. 8.3 Staff who have been identified as a close contact: advice added for staff who participated in vaccine trial or are medically exempt from vaccination. Additional clarifications added, including HPT ability to override close contact exemptions of staff e.g. during an outbreak or following the identification of a new SARS-CoV-2 variant. 8.4 Staff testing: updated to advise HPT risk assessment required before ending self-isolation if staff receive positive LFD test and PCR negative result. Linked out to letter regarding daily LFD testing for HSCWs. 9 Visiting arrangements for family and friends: section restructured and advice updated. This includes advice for named visitor policy during an outbreak in the care home, external visiting groups, testing advice for children aged 12 and over, and visiting arrangements for residents who are self-isolating (non-outbreak). Appendix 1: tables removed and link to contact details added Appendix 2: table 1e and additional notes updated with latest advice
V2.4	08/09/21	1 Measures to prevent spread of COVID-19: physical distancing advice updated 1.2 Vaccination programme: latest advice and evidence updated 3.1 Outbreak management: clarifications of HPT role added 8.4 Staff who have been identified as a contact of a COVID-19 case: the criteria for staff exemption for self-isolation and returning to work when identified as a close contact updated 9 Visiting arrangements in care homes: visiting arrangements for residents who are isolating as a contact, for admission to care home purposes or international travel reasons has been updated. Physical distancing advice for day services in care home settings updated.

Contents

Scope of the guidance

This guidance is to support those working in care home settings and users of their services about COVID-19. It should be used for care homes for adults and older people, that is, all care homes registered with the Care Inspectorate, excluding those for children and young people.

- Guidance for community respite services not registered as care homes should refer to **COVID-19: guidance for social, community and residential care settings**.

For Infection Prevention and Control guidance for Care Home Settings, see the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum**, produced by ARHAI Scotland, our national partner organisation for **IPC**.

This guidance is based on what is currently known about COVID-19.

Public Health Scotland (PHS), a newly formed national NHS organisation since April 2020, now incorporating the former Health Protection Scotland of NHS National Services Scotland, will update this guidance as needed and as additional information becomes available.

Further PHS COVID-19 guidance for other settings is available on the **PHS website**.

We would like to remind readers to regularly check the main **Scottish Government COVID-19 page** for updates on general mitigation measures and new response strategies.

1. Introduction

The disease COVID-19 is caused by a new strain of coronavirus (SARS-CoV-2) that was first identified in Wuhan City, China in December 2019. The first cases in the UK were detected on 31 January 2020. COVID-19 was declared a pandemic by the World Health Organization on 12 March 2020.

A range of measures are being used to control transmission of COVID-19, including vaccination, physical distancing, hand hygiene, environmental cleaning and ventilation, specific personal protective equipment (PPE) for health and social care settings, face coverings, testing and contact tracing and a selection of societal restrictions, as appropriate. Contact tracing is undertaken for cases confirmed by a positive polymerase chain reaction (PCR) test and for lateral flow device (LFD) testing. In Scotland, the programme of community testing, contact tracing, isolation and support is known as '**Test and Protect'.**

Further details on COVID-19 can be found on **NHS inform** and the Scottish Government **website**. Advice for residents, family and friends about visiting in care homes as safely as possible during the pandemic is also available on **www.nhsinform.scot/openwithcare**.

This guidance is relevant to all services registered with the Care Inspectorate as **care homes for adults and older people.** Other residential care services should refer to the **COVID-19: guidance for social, community and residential care settings**. When in doubt, advice on which guidance to use for specific circumstances is available from the local Health Protection Team (HPT).

1.1 Symptoms of COVID-19 for residents in care home settings

The cardinal symptoms of COVID-19 are:

- new continuous cough or
- fever or
- loss of/ change in sense of smell or taste

However, symptoms of COVID-19 vary in severity from having a fever, cough, headache, sore throat, altered sense or absence of taste or smell, diarrhoea, general weakness, fatigue and muscular pain to pneumonia, acute respiratory distress syndrome and other systemic complications.[1] Mortality is an unfortunate potential outcome in those with severe disease.

It is also useful to note that older or immune-compromised individuals including residents may present with atypical or non-specific symptoms, which can include:

- increased confusion,
- reduced appetite (and sometimes vomiting and diarrhoea),
- headache,
- shortness of breath,
- falls,
- dehydration and,
- delirium or excessive sleepiness.

Difficulty breathing is also an important symptom to be aware of in older adults, but can be late in appearing. For more details on clinical presentation and symptoms, see the **Scottish Government symptom checker infographic**.

1.2 Spread of COVID-19 in care homes

Transmission of SARS-CoV-2 mainly occurs through close contact with an infectious individual, mediated by respiratory particles, also known as droplet transmission between individuals.[2] People may also potentially acquire the infection by contact with contaminated objects or surfaces (fomites). However, infection can often be attributed to a number of different transmission routes and separating fomite transmission from other routes in real-life scenarios is difficult. The SARS-CoV-2 virus can survive on surfaces for periods ranging from a few hours to days.[3] However, the amount of viable virus declines over time and it may not always be present in sufficient quantities to cause infection,

despite viral RNA persistence. Further discussion of the evidence on transmission routes is available **here**.

An Aerosol Generating Procedure (AGP) is a medical procedure that can result in the release of airborne particles from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted from the respiratory tract. AGPs (e.g. CPAP and BiPAP) are rarely undertaken in care home settings but if so, guidance within the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** should be followed.

The European Centre for Disease Prevention and Control (ECDC) states that the infectious period begins around two days before symptom onset to 10 days after, but people are most infectious during their symptomatic period, usually in the first 3 days.[4] WHO advises the average incubation period is between 5 - 6 days, however it can range from 1-14 days.[5] There is evidence of asymptomatic transmission of COVID-19.[6]

2. Measures to prevent transmission of COVID-19

This section outlines measures that are recommended to help reduce the transmission of COVID-19 and to protect people, especially those at higher risk. They apply to the general population, the rest of this guidance outlines care home specific aspects. For all IPC required measures see the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum**.

The implementation of the COVID-19 mitigation measures detailed in this section should be regularly reviewed by each care home.

2.1 Test and Protect

Guidance for households with possible or confirmed COVID-19 (self-isolation) should be followed by people with symptoms or a COVID-19 diagnosis, or those required to self-isolate as a contact of a case, to reduce the community spread of COVID-19. Guidance for households with possible coronavirus infection can be found on **NHS inform**.

Contact tracing is an effective public health intervention aimed at breaking transmission links. It relies on good understanding, communication and compliance. **Test and Protect** supports this approach. Everyone who tests positive for SARS-CoV-2, regardless of the variant type, will be contacted by Test and Protect to identify their contacts, either through digital routes or by phone call. This approach operates by identifying cases of COVID-19, tracing the people who may have become infected by spending time in close contact with them, and then supporting those close contacts to self-isolate where required, so that if an infection develops, they are less likely to transmit to others. Individuals who are identified as contacts should self-isolate and arrange to be tested - see **here**.

Some individuals may be exempted from **self-isolation** or the period of self-isolation may be shortened, based on the contact's age, vaccination status and any history of recent COVID-19 infection. However, Test and Protect may advise in certain situations that completion of the self-isolation period is required even if an individual is eligible for an exemption to self-isolation as a close contact. For further details on contact tracing and self-isolation:

- care home residents - see **section 5** and **section 6**
- care home staff - see **section 8.4** and **section 8.7**
- the general public - see **NHS inform** and the Scottish Government **website**.
- returning international travellers – see **COVID-19: international travel and managed isolation (quarantine)** and **Appendix 2**.

2.2 Physical Distancing

Physical distancing measures are a key mitigation in the prevention and management of COVID-19 illness by reducing the likelihood of droplet transmission between people. People should aim to keep close contact to a minimum and continue to avoid crowded areas, in particular where high levels of ventilation are not possible, such as indoors and in certain residential settings. Further information is available from **NHS inform** and the Scottish Government's **review of physical distancing in Scotland**.

Physical distancing guidance for care home settings is detailed below. See the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** for more information on physical distancing in care home settings.

- Physical distancing between residents in the care home is no longer required.

- Staff must aim to maintain 1 metre or more physical distancing from residents when not delivering care which requires physical contact, wherever possible and use a Fluid Resistant Surgical Mask (FRSM) at all times, unless in **certain situations** (e.g. for lip-reading, to avoid distress). This is particularly important when within 2 metres of residents - see **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** for more information on PPE use. This advice also applies to staff when outdoors in the care home grounds.

    - 2 metre physical distancing should be maintained for residents on the **respiratory pathway**, e.g. COVID-19 cases, as detailed in the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum**.

- Physical distancing between care home staff has reduced to at least 1 metre provided FRSM are in use - see **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** for more information on PPE use.

- Where staff remove FRSMs for any reason e.g. eating, drinking, changing, staff should maintain 2 metre physical distancing. Such distancing reduces the risk of transmission between staff, who could nonetheless be identified as close contacts should a case arise among staff. Staff should be supported by their organisation to remind their colleagues when they drop their guard during application of COVID-19 controls.

- Outbreaks amongst staff have been associated with a lack of physical distancing in changing areas, recreational and rest areas during staff breaks, as well as car sharing. It is particularly important to utilise all available rooms and spaces to allow

staff to change and have rest breaks without breaching 2 metre physical distancing (recognising that staff will not be wearing FRSM in these areas).

- **Car sharing** should still be avoided whenever practical and mitigations should remain in place otherwise. The same mitigations apply to larger vehicles (e.g. mini-buses).

Physical distancing advice for staff and residents when out with the care home, including when travelling, is included in **section 7.4** of this guidance. For physical distancing advice for visitors - see **section 9** of this guidance.

2.3 Ventilation in the Care Home

Improving ventilation in the care home can also reduce spread of COVID-19 infection. Consideration should be given to maximising the amount of fresh air entering a room, wherever possible, particularly if the residents and staff feel too warm or if the room feels stuffy.

Natural ventilation can be achieved by opening windows, vents and doors (excluding fire doors). Some buildings may have mechanical ventilation systems, these should maximise the amount of fresh air being introduced and minimise the recirculation of air in rooms and throughout buildings. However, it is also important that the well-being and thermal comfort of residents and staff be maintained by ensuring adequate room temperatures in the care home. 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, especially in those who are 65 years or older, or have a long-term health condition.

For more information on ventilation and practical steps on how to improve ventilation see:

- Scottish Government **COVID-19: ventilation guidance**
- Scottish Government **sector advice cards** for ventilation advice for employers and ventilation advice for everyone
- HSE **Ventilation and air conditioning during the coronavirus (COVID-19) pandemic** guidance

- ARHAI Scotland **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum**

In the situation that a resident in their own private room still feels too warm after the heating has been turned off and the windows have been opened, then a fan may be used provided the fan is clean, directed away from the door and well maintained. In an outbreak situation or if the resident is on a respiratory pathway, fans are permitted in a resident's own room but windows should remain open when in use.

However, the use of fans in communal areas of the care home (outside the residents' private room) must only be used following a thorough risk assessment and during exceptionally warm weather. Care home staff should turn off the heating and open windows and doors (if possible) to reduce the temperature in the care home before using a fan, as fan use should be as an exception and not routine. Fans must not be in use where care homes have COVID-19 cases or an ongoing outbreak of COVID-19 or any other infectious pathogen. If the risk assessment results in use of fans, it is essential that fans are cleaned regularly (including the blades) and are not pointed directly at residents.

2.4 Those at the highest risk of severe illness if they develop COVID-19

The Scottish Government have published **advice for people at the highest risk** of severe illness (who were previously advised to shield), to avoid infection and development of COVID-19, and to help them make informed decisions. This advice does not generally apply to residents in a care home who should follow this PHS guidance and the separate **Scottish Government COVID-19: adult care homes guidance**.

Staff with underlying health conditions that place them at higher risk, should discuss this with their line manager or local Occupational Health service. **The COVID-19 Occupational Risk Assessment Guidance** can be used to support managers to undertake an individual occupational risk assessment. Pregnant staff can also seek advice from their line manager or local Occupational Health service. Further information for at-risk or pregnant healthcare workers can be found in **Guidance for NHS Scotland workforce Staff and Managers on Coronavirus**. To note that in line with experience and the

evidence base acquired to date, vaccination is strongly encouraged for all adults, including those who are pregnant - **section 2.6** more information on vaccination.

2.5 Face coverings

Face coverings: everyone needs to be aware of and follow the **Scottish Government guidance** on face coverings which are key to reducing droplet transmission, especially in crowded public places. Note that face coverings are not considered clinical PPE.

2.6 Vaccination programme

The COVID-19 vaccination programme commenced in the UK in December 2020. The **COVID-19: the green book, chapter 14a** provides information on COVID-19 vaccines in the UK, the vaccine schedule for the UK and recommendations for use of the vaccine.

The Joint Committee for Vaccines and Immunisation (JCVI) provides details on the **groups that are to be prioritised for vaccination**. The JCVI has recommended that the second dose of both vaccines should be routinely scheduled from between four and twelve weeks after the first dose. A booster COVID-19 vaccine is now advised for everyone 18 years and above - care home residents and staff are strongly encouraged to accept the booster vaccination. See **NHS inform** for more information. Vaccination of all staff is strongly recommended, including those who are pregnant, breastfeeding or planning a pregnancy, where the safety profile for COVID-19 vaccination remains good.

The excellent uptake of vaccination in care home staff and residents has altered the COVID-19 mitigation measures (for both vaccinated and unvaccinated people) to be implemented in such settings:

- Fully vaccinated people who are identified as contacts may not need to self-isolate for the full self-isolation period, as long as certain criteria are met. See **section 8.4** for more details, in particular regarding health and social care workers.
- Self-isolation requirements for **returning travellers** can also vary based on vaccination status.

- **Physical distancing** in care homes has been relaxed, as it is no longer in place between residents. For **care home staff**, the minimum physical distance they should maintain has been reduced to 1 metre or more in most circumstances.

- Resident visits on day trips or overnight stays.

- However, care home residents are still currently required to self-isolate for 14 days if identified as a contact regardless of vaccination status (**see section 6**).

- Vaccinated and unvaccinated people should continue to comply with ALL testing regimes and follow IPC advice in the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum.**

For information on COVID-19 vaccination when there are suspected or confirmed cases of COVID-19 in the care home - see **COVID-19: the green book, chapter 14a** and **Scottish Government guidance**. Vaccination is not yet used as a tool in managing outbreaks, where the risks and benefits of a vaccination session during an outbreak must be carefully considered, in particular the ability to vaccinate whilst maintaining IPC measures. The local HPT can be contacted to undertake a risk assessment in order to determine when vaccination sessions can be supported if a care home is affected by an outbreak.

It is advisable that for people who have had a confirmed diagnosis of COVID-19, vaccination is deferred for four weeks after onset of symptoms (or first confirmed positive test in those who are asymptomatic) in order not to confuse the significance of symptoms.

Evidence for vaccination across adult age groups shows protection against symptomatic disease, infection (including in healthcare workers and in care home residents), hospitalisation due to severe illness and mortality, for all vaccines licensed for use in the UK. The observed reduction in both symptomatic and asymptomatic infections suggests that vaccination has the potential also to reduce transmission. A summary of the most recent data on real world effectiveness is published on a weekly basis as part of **PHE COVID-19 vaccine surveillance reports** and are regularly updated into the **COVID-19: the green book, chapter 14a**.

Additional sources of information for the COVID-19 vaccination are available:

- **COVID-19 vaccination guidance: consent in care homes in Scotland (for care home managers)**
- **COVID-19: guidance for Health Protection Teams (HPTs)**
- Workforce education materials are available on the **Turas Learn site**
- Leaflets explaining why the coronavirus (COVID-19) vaccine is being offered and how, when and where it will be given, are available on **NHS inform**
- Resources from Public Health Scotland are available to promote the COVID-19 immunisation programme to **frontline healthcare worker staff** and to **social care worker staff**
- Answers to FAQs available in **COVID-19 vaccination guidance for health and social care professionals**
- More information on the COVID-19 vaccine is available on **NHS inform** and a helpline for the public has been set up on 0800 030 8013

2.7 Infection Prevention and Control (IPC)

ARHAI Scotland have produced **Infection Prevention and Control Guidance for Winter (2021/22), Respiratory Infections in Health and Care Settings**. It recognises the likelihood of a surge in a number of respiratory viruses/infections in addition to COVID-19 over the winter season of 2021/22 and supersedes the three COVID-19 addenda (community health and care settings, acute settings and adult and older people care homes) first published in October 2020.

Care homes must refer to the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** for all evidence based IPC measures and advice.

It is important that users access the online version in order to ensure they obtain the most up to date information and advice.

Please note that practising good hand hygiene is important when touching any items in the care home, including Christmas presents and decorations, which do not require to be wiped down or quarantined for 72 hours.

3. Providing care for residents during COVID-19 pandemic

It is useful to acknowledge that for care home residents, many of whom can be frail, this setting is their own home and guidance is evolving towards a situation of normalisation, keeping in place safeguards as required.

Care homes are advised to ensure daily monitoring of all residents for COVID-19 symptoms, or other signs of illness and testing with PCR if any arise. This generally involves being alert to the above symptoms and changes in health or behaviour. Residents with cognitive impairment may be less able to report symptoms. See the **Scottish Government symptom checker infographic** for more details.

Contact GP services according to local pathways for clinical advice on further management if a resident becomes unwell. If urgent ambulance or hospital care is required, dial 999 and inform the call handler or operator that the unwell person may have COVID-19.

3.1 Outbreak management in a care home

A COVID-19 outbreak is defined as two or more linked cases of disease within a defined setting over a period of 14 days. For care homes specifically, with respect to COVID-19, an outbreak should be suspected, though not yet declared, when there is a single new case with symptoms consistent with COVID-19 infection arising in the care home, likely to be due to spread of the virus within that setting. This suspicion should trigger an immediate review of all residents' health status to ascertain whether there may be other possible or probable COVID-19 cases. Vigilance for symptoms in staff is also, as always, necessary.

On identification of a new possible, probable, or confirmed COVID-19 case, the care home must immediately contact the local HPT (or IPCT) who will undertake an assessment of the situation including the adequacy of IPC measures and will advise on the need for testing of residents and staff. Based on a risk assessment of the case and the care home circumstances, whole home testing of all residents and staff will be carefully considered at this point. See **section 4: testing in the care home** for additional information.

Assessment of resident cases when considering any potential outbreak should also include possible, probable or confirmed cases who have either been transferred from the care home to hospital or died within the same time period. Symptoms and cases in staff must also be considered.

Whilst potential staff or resident cases are being investigated, the HPT will advise whether other measures are required or not such as limiting group activities, communal eating, external visits or routine visiting, by taking a risk assessment approach. It is expected that such restrictions would ensue once an outbreak of two or more linked cases has been declared by the HPT (note: it is not for the care home to declare an outbreak).

There is discretion for local HPTs to assess whether whole home testing is appropriate where, for example, a weak PCR positive result in a staff member turns out to be negative upon re-testing or there is a false positive result for another reason. If, for whatever reason, the HPT decide not progress with whole home testing after one case (e.g. a false positive test), this will be re-considered if a second case arises. At the individual level, whole home testing should not include individuals who are distressed by the procedure.

These criteria may apply to other non-care home residential settings during the investigation of potentially linked cases if there are clinically vulnerable individuals or extremely vulnerable individuals living in group settings. This will need to be considered on an individual service basis.

An outbreak will be declared by the local HPT following identification of two linked cases, at least one of which has been laboratory-confirmed. At this point, whole home testing of all residents and staff may be actively re-considered as part of the initial risk assessment of the outbreak situation. A number of other measures are also key to progress, as guided by the HPT, including regular monitoring of physical distancing, restriction of resident movements within and out of the home, appropriate PPE usage, enhanced cleaning and

restrictions on resident transfer and routine and named person visiting. See the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** for advice on these measures, including information on cohorting of residents and staff.

The use of LFD (lateral flow device) tests on symptomatic individuals or on residents during an outbreak in a care home, where symptoms can be indistinct, is not advised due to the relative low sensitivity of such tests, which carry an important risk of false negativity, i.e. cases may be missed. PCR testing is more useful and reliable in such circumstances, where limited movement of residents, visitors and staff and other infection control measures will already have been reinforced. The use of repeated rounds of whole home testing as a means of monitoring progress must be considered carefully and balanced against the time and staff resource this entails, the impact this may or may not have on determining next steps, as well as discomfort or potential distress on the part of the resident. Such ongoing screening must be justifiable and is for the HPT to determine.

Transfers of residents in and out of the care home during an outbreak must be risk assessed and considered carefully (e.g. size of the outbreak, spread within the care home, which units are affected, physical layout of the building, vaccination status of the individual and coverage at the care home) with support of the local HPT managing the outbreak. Any receiving service (e.g. hospital ward or ambulance) must be advised of the IPC measures in place for each resident they support.

For the HPT to declare an outbreak over, there should be no new symptomatic or confirmed COVID-19 cases for a minimum period of at least 14 days from last possible exposure to a case, whether in a resident or staff. The HPT must also be satisfied that existing cases have been isolated/cohorted effectively and that guidance on IPC and other interventions is being applied appropriately. There should be sufficient staff to enable the care home to operate safely using PPE appropriately.

The **COVID-19 care home outbreak checklist** can be used as a supplementary tool when managing an outbreak in a care home setting.

Care homes are expected to report all incidents and outbreaks to their regulator, usually the Care Inspectorate, as well as to their local HPT. Local HPTs continue to lead on outbreaks in care homes, according to their statutory duties under the Public Health Etc.

(Scotland) Act 2008, often, though not always, through the setting up of an Incident Management Team. IMTs are not always convened now, since outbreaks are, overall, milder in nature since the advent of vaccination. Regardless of whether an IMT has been constituted, the local HPT has a duty to support the care home in the management of the outbreak and makes decisions on outbreak control using a risk assessment approach, according to the particular circumstances of the outbreak and the care home itself.

All care in care home settings aims to bring dignity to residents' lives, whilst also ensuring safeguarding of this vulnerable group during this period of pandemic risk. The vaccination of older people and in particular care home residents and staff, (though not 100% effective in COVID-19 prevention) has enabled progress to be made towards easing some of the control measures that were placed on care homes to protect residents and staff at previous stages of the pandemic. However, care home residents are still a vulnerable population and communal living arrangements present additional risks. Further easing of measures in care homes will be possible when more evidence is available to support this, as a fine balance must be struck such that person-centeredness must work in combination with measures to protect residents, staff and the wider population. IPC measures detailed in **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** should continue to be followed.

4. Testing in the care home

All care home residents who develop symptoms suggestive of possible COVID-19 infection should be tested by PCR as part of clinical assessment. **Section 5** should be followed for advice.

Any staff presenting with suspected COVID-19 symptoms should be sent home immediately and advised to be tested by PCR. Similarly, if they report illness from home, they are advised to self-isolate and arrange to be tested as soon as possible, ideally within 3 days of symptom onset. See **section 8.5 staff testing** for further information.

Testing of residents or staff and must be done with consent or provision, for those without capacity, made otherwise.

If either residents or staff have previously had a laboratory-confirmed diagnosis of COVID-19 and are within 90 days of this, they require re-testing if new symptoms of COVID-19 develop or when they are identified as close contacts. Routine occupational screening with PCR can be deferred until 90 days have lapsed since the last PCR positive test since their pre-test probability is likely to be low. This is mainly to avoid a PCR positive result due to remnant RNA material from being interpreted as a new case (false positive). Routine LFD testing (twice weekly until recently) should continue, despite past PCR positive results in the past 90 days. The 90-day period should start from the date of COVID-19 (cardinal) symptom onset or the first positive test, if asymptomatic or other symptoms. As always, care should be taken for more subtle symptoms in the older resident population, which can mask SARS-CoV-2 infection.

See **section 3.1** for when an outbreak is suspected. Further to this, any care home that has employed staff, including agency staff, linked with the facility where an outbreak has been declared, must also be assessed for wider testing as part of the heath protection response.

The previous requirement to undertake periodic sampling testing of residents in the absence of an outbreak has now evolved and each HPT should assess whether such 'sampling screening' is required of residents.

PCR testing in the care home is now achieved using Regional Hubs (the UK Government social care testing portal was used previously). Care home staff should now use the COVID testing portal - see **www.covidtestingportal.scot** for both PCR and LFD testing. Should care home staff have any queries, they can contact the COVID Testing Support Service Helpline (0800 008 6587 - available 08:00 to 20:00 every day) or use the **'Support'** button from within the COVID testing portal for any IT related portal queries.

For further information on testing in the care home, see **COVID-19: Care Home Guidance for use of Lateral Flow Device testing (designated visitors, enhanced staff testing, outbreak management)**.

Further information on testing is provided in this guidance:

- See **section 3.1** for testing information during an outbreak
- See **section 7** for admissions testing

- See **section 8.1** for testing of professional visitors to the care home information
- See **section 8.4** for staff testing information
- See **section 9** for testing of visitors to the care home information

5. Management of symptomatic or PCR test positive care home residents

All symptomatic or COVID-19 diagnosed residents in the care home should be isolated immediately for 14 days from the date of symptom onset (or date of first positive test if asymptomatic) and medical advice sought if indicated. See **Table 1** for further information.

Families and residents should be made aware of scope to have essential visits where these are helpful or necessary.

Table 1. Summary of actions in response to PCR test positive in care home residents

Symptom status at time of testing	Action
Symptomatic at time of testing	Isolate for 14 days from date of symptom onset. Isolation can be discontinued after both completion of 14 days of isolation and if the individual has been apyrexial for 48 hrs (without use of anti-pyretics). No further testing is required.
Asymptomatic at time of testing and remains asymptomatic	Isolate for 14 days from date of PCR positive test. Isolation can be discontinued after both completion of 14 days of isolation and if the individual has been apyrexial for 48 hrs (without the use of anti-pyrexials). No further testing is required.
Asymptomatic at time of testing and becomes symptomatic	Isolate for 14 days from date of PCR positive test. If symptoms develop during this isolation period, then a further 14 days of isolation must commence from symptom onset date. Isolation can be discontinued after both completion of 14 days' isolation including any extension of this and if the individual has been apyrexial for 48 hrs (without the use of anti-pyretics). No further testing is required.

Self-isolation requires the resident to be placed in a single room with en-suite facilities, where possible. The door should be kept closed. Where this is not possible, ensure the bed is moved to the furthest safe point in the room to achieve a 2 metre physical distance to the open door. Clearly signpost the rooms by placing IPC signs, indicating droplet precautions, at the entrance of the room or area. Confidentiality must be maintained. See the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** for information on cohorting of residents. Additional support may be required for residents who experience difficulty remaining in their room when following self-isolation advice, e.g. residents who walk with purpose, experience confusion or distress.

Where en-suite facilities are not available, a commode that only that resident will use should be designated, if possible. If a commode is used and cannot be dedicated to the resident, ensure it is cleaned as per the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** guidance. Where en-suite facilities are not available, staff should ensure residents are assisted with hand hygiene after using the commode, with either a basin of warm water and soap applied to the hands or hand cleansing wipes, Alcohol Based Hand Rub (ABHR) should be applied afterwards.

Only essential staff should enter the resident's room, wearing appropriate PPE. See **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** for further details on PPE. All necessary procedures and care should be carried out within the resident's room. Entry and exit from the room should be minimised during care, especially when care procedures produce respiratory droplets or aerosols.

Isolation can be discontinued as per the advice in **Table 1**.

Before IPC measures are stepped down, consideration must be given to any additional ongoing IPC measures which may be required for loose stools or any other infectious organisms, see **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** for more information.

If a transfer to hospital is required, the ambulance service and the receiving ward/department must be informed if the resident is a possible, probable or confirmed COVID-19 case and of the requirement for isolation on arrival. Where transfer of a non-COVID-19, possible, probable or confirmed case occurs, the receiving service must be advised of the ongoing outbreak in the care home.

The environment must be cleaned as detailed in the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** section before any other residents use the facilities.

Considerations for symptomatic PCR test negative residents

In the event a symptomatic resident's test is negative to PCR testing, consideration should be given to further clinical assessment of the symptoms, or repeat testing in case this is a false negative result or was taken too early after symptom onset. Residents who are identified as possible cases can be released before their 14-day self-isolation ends, with a negative result if:

- the sampler was adequately trained and the sample was not deemed unsatisfactory
- the resident has not been otherwise identified as a close contact of another resident, staff or other individual within the previous 14 days
- the resident is not under quarantine for travel reasons nor completing 14 days' isolation following hospital discharge, when relevant
- the resident has been well and apyrexial for 48 hrs (without the use of anti-pyrexials); discussion with the GP may be helpful to confirm clinical management.

6. Measures for residents exposed to a case of COVID-19

Where a resident has developed symptoms or has been diagnosed with COVID-19 (whether they have symptoms or not) within a care home, an assessment of risk should be undertaken to establish the nature and duration of exposure and contact with others, known as contact tracing. This should be discussed with the local HPT.

Residents who are identified as contacts should be isolated individually in single rooms for 14 days after last exposure to a possible, probable or confirmed case. This should be the preferred option whenever possible. Where all single occupancy rooms are occupied, cohorting of exposed residents may be considered. Residents who are considered at highest risk if they develop COVID-19 should not be placed in a cohort. Cohorting of residents should be discussed with the local HPT. See the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** for more information on cohorting of residents.

Contacts of a possible or probable case can be released from self-isolation if the possible or probable case's result does not confirm infection.

During their 14-day contact self-isolation period, all residents identified as close contacts (who both are well enough and not cases themselves) can be supported to go outdoors if accompanied by staff, and if the care home has outside space, without restarting their isolation period. This also applies to residents who are self-isolating as new admissions to the care home. See **section 9.2** for information on visiting arrangements. Outdoors in this context means within the boundaries of the care home grounds. This is subject to carefully considered risk assessment by care home management that takes into account the safety of the resident and other residents within the care home. Residents should wear a FRSM and maintain physical distancing if they are required to walk through any communal areas of the care home to gain access to outside space in these circumstances.

If a resident leaves the care home for personal or social purposes, and is subsequently identified as a contact of a case during this time, they should self-isolate for 14 days after last exposure to the case as per the above advice. The advice to the general population to shorten a period of self-isolation if identified as a close contact of a case when certain conditions are met, does not apply to care home residents. A cautious but measured approach to this is being followed at present due to the vulnerability of the care home setting.

As in the community, all identified contacts of a case should be offered PCR contact testing even if they are asymptomatic.

Residents should continue to be carefully monitored for any symptoms of COVID-19 during the 14-day period from last exposure. If symptoms or signs consistent with COVID-19 occur in that period, relevant diagnostic tests, including for SARS-CoV-2, should be performed, even if the resident previously tested negative during the current self-isolation period as a contact. If the PCR test is positive and they have been cohorted with other residents, the other residents' follow-up period recommences from the date of last exposure to this new case. Ensure that residents who have had no contact with COVID-19 cases are separated from residents with symptoms or a diagnosis of COVID-19.

7. Admission of individuals to the care home

The 14-day self-isolation requirement for admissions to care homes depends on which setting a resident is transferring from and can be at the discretion of the local HPT.

The Cabinet Secretary's statement on 21st April 2020 stated that the following groups should be screened:

- all COVID-19 patients in hospital who are to be admitted to a care home (See **section 7.1**)
- all other admissions to care homes

Any testing on admission to care homes should be undertaken with consent and not taken forward if the resident declines or is distressed. If transferring remains in the clinical interests of the resident, a risk assessment can support this process and local HPTs can advise in such complex situations.

For residents without the capacity to consent to a test, see **Adults with Incapacity (Scotland) Act 2000: principles** for further information.

PCR screening of residents only provides partial reassurance since infection may still develop at any time during the 14 day incubation period.

In addition, interpretation of PCR results can be challenging for this group of older vulnerable individuals, who may be affected by a degree of immuno-compromise. PCR positivity may indicate RNA remnant (or dead virus) if testing occurs between 14 and 90 days of symptom onset (or test positivity, if asymptomatic), hence re-testing during this period has not generally been advised in the absence of symptoms. With the advent of Omicron, a highly transmissible SARS-CoV-2 variant, re-testing of contacts who have been PCR positive in the past 90 days is being re-considered.

Prior to admission at the care home, respiratory screening questions should be undertaken as advised in the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum.**

7.1 Admission of COVID-19 recovered residents from hospital

Since RNA testing can take several weeks after infection to revert back to negative due to persistence of non-viable viral RNA remnants, repeat PCR testing within 90 days of a COVID-19 diagnosis in preparation for discharge will not be useful and must be considered carefully. Therefore, COVID-19 recovered residents in hospital can be discharged to the care home 14 days after symptom onset (or first positive test, if asymptomatic) without further testing. In such instances, discharge at 14 days, providing the person is clinically stable and afebrile for 48 hours without anti-pyretics, is based on clinical judgment of fitness for discharge. This decision should be made in collaboration with the receiving care home manager who needs to agree to patient transfer before this occurs. Discharging residents who are considered fit for discharge from hospital to the care home should always be supported, as residents returning to their homely environment, rather than remaining in a clinical setting, is encouraged for their recovery and general wellbeing. If COVID-19 recovered patients have completed their 14 days of isolation in hospital, no further isolation is required on return to the care home. This applies to both returning and new residents being discharged from hospital into the care home.

If a COVID-19 recovered resident is to be discharged before their 14-day isolation period has ended, it is advisable they have two negative PCR tests before discharge from hospital. Tests should be taken at least 24 hours apart. The testing requirements in these circumstances are currently under review with Scottish Government. As the resident has not completed their 14 days' isolation then they can do so in the care home, and do not require to start a new period of isolation, nor do they require further testing, once this isolation period is completed.

Where it is in the clinical interest of the resident and negative testing is not feasible (e.g. resident does not consent, detrimental consequences or it would cause distress), a risk assessment and a care plan for the remaining period of isolation up to 14 days in the care home must be agreed.

For further details, see the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum**, which also includes advice for residents discharged from hospital.

7.2 Admission of non COVID-19 residents from hospital

All non-COVID-19 residents being discharged from hospital should be isolated for 14 days from or including the date of discharge from hospital.

Risk assessment prior to hospital discharge for residents with a non-COVID-19 diagnosis should be undertaken in conjunction with the care home. Discharging residents who are considered fit for discharge from hospital to the care home should always be supported, as residents returning to a homely environment, rather than remaining in a clinical setting, is encouraged for their recovery and general wellbeing.

A single negative PCR result should be available preferably within 48 hours prior to discharge from hospital. The testing requirement in this circumstance is currently under review with Scottish Government. The exception is where a resident is considered to suffer detrimental clinical consequence or distress if they were not able to be discharged to a care home. In these cases, the resident may be discharged to the care home without a test result being available, but the 14 days of isolation must be completed regardless, in the care home.

7.3 Admissions from the community

Self-isolation for residents on admission to the care home from the community (including transfers from other care homes or hospices) follows a risk assessment approach. A risk assessment should be agreed on a case by case basis by the care home manager to determine whether the resident should isolate for 14 days on admission to the care home. The decision on this is at the care home manager's discretion, which may be subject to local risk assessment processes as guided by the local oversight group. A clinical or heath protection view may also be sought, on occasion, to support this process.

Facilities should also be assessed, taking into account requirements for the resident's care (e.g. en-suite facilities if a period of self-isolation is required, possibilities for improved ventilation through window opening, room sizes).

The individual risk assessment for each admitted resident as to whether they should self-isolate on admission can include factors such as

- COVID-19 symptoms in the resident
- COVID-19 symptoms and status of household/setting they have come from
- close contact status of resident
- resident vaccination status
- resident travel history
- care home staff and resident vaccination uptake rate
- general IPC and PPE training/supplies/usage in the care home and
- COVID-19 status of the receiving care home, i.e. is there an ongoing outbreak?

All admissions from the community (including admissions from other care homes and hospices) should have one negative PCR test returned within 3 days of their admission date. In exceptional circumstances where testing is not possible before admission then testing on admission to the care home is acceptable. **Where it is in the clinical interest of the resident and negative testing is not feasible** (e.g. resident does not consent, detrimental consequences or it would cause distress), an agreed care plan for admission to the care home will document this. Advice on this process is available from the local Health Protection Team, if needed.

7.4 Residents who temporarily leave the care home

Residents who temporarily leave the care home to attend essential personal business, e.g. attending a funeral, attendance at hospital A&E, planned out-patient's appointment or as a day case, do not require the same control measures for testing and self-isolation as a new admission upon their return.

For social visits, the Scottish Government have produced Open with Care - see **COVID-19 adult care homes guidance**. It contains guidance on personal and social outings for residents, including day visits to public and private spaces and overnight stays, and recommends residents should be supported to leave the care home in line with their wishes.

Symptom vigilance amongst residents and their friends and family when planning outings away from the care home is an important measure. Friends and family members are also encouraged to take a LFD test before meeting with residents outwith the care home, particularly if an overnight stay is planned - see **NHS inform** for details on LFD tests.

The physical distancing and face covering guidance on **NHS inform** can be followed by care home residents during outings outside of the care home, as for the general public. However, the virus is still circulating and transmission is still possible even when a person has been vaccinated, though a milder disease may ensue. Residents and their carers must be made aware of this risk during the planning of such outings, particularly when the course of vaccination has not yet been completed.

Staff may also take residents on visits outwith the care home. Please note there is no requirement for residents or staff to wear PPE. Staff and residents should follow the rules on face coverings including in certain indoor and outdoor public places as detailed in the **Health Protection (Coronavirus) (Requirements) (Scotland) Regulations 2021**. They should also follow other **general guidance** on masks and face coverings as appropriate during their visits away from the care home and they are not required to change their clothing on return. If staff are within 2 metres of the resident or are providing direct care whilst out of the care home, then they should use a Fluid Resistant Surgical Mask (FRSM) and any other necessary PPE, as per the PPE guidance contained within the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum**. Physical distancing between residents and staff should be maintained when they are on visits and outings away from the care home, where safe enough to do so. This also includes maintaining 1 metre or more physical distancing between residents and staff during a shared vehicle journey, wherever possible. Further mitigations include opening windows to increase ventilation, FRSMs for staff and face coverings for residents, if tolerated. Residents do not need to physically distance between themselves during shared vehicle journeys. Staff should continue to wear FRSM during shared vehicle journeys, as noted above.

Self-isolation and testing of residents is not routinely recommended on return from day visits away from the care home or non-healthcare overnight visits, which are permitted. However, in response to the appearance of the Omicron variant of SARS-CoV-2, the Scottish Government wrote a letter to care homes, **COVID-19: minimising the risk over**

winter and updated protective measures for Omicron variant, to inform them of additional measures that should be taken to minimise the risk of transmission of the new variant. This includes a recommendation for residents to undertake an LFD test before leaving the care home and to undertake an LFD test every second day upon return for fourteen days, unless this would cause harm or distress. Residents returning to the care home should also be assessed using the **respiratory screening questions** in advance of their immediate return to the care home. Only exceptionally will residents self-isolate on return from outings. This may be based on COVID-19 clinical concerns or where the Health Protection Team indicates isolation is required based on a risk assessment, for example the resident is a close contact of a case.

Should a resident be unfortunate enough to be identified as a close contact whilst on an outing or to become symptomatic or COVID positive, provision must have been made through the planning process prior to leaving the care home, that they can choose to return to their care home and complete the self-isolation period of 14 days as required. However, the resident may choose to remain away from the care home provided the conditions for self-isolation exemption are understood by them and their carers - see **section 5** and **section 6** for more details.

If an outbreak develops in the care home whilst the resident is away, the resident can choose to remain away or return to their care home, recognising that it is their place of residence and home. The local HPT should advise on such decisions which need to be discussed and agreed with the individual, their family and take into account the nature of the outbreak, the risks posed and whether the care home is able to isolate and care for (if needed) the individual on return.

7.5 Admissions to residential respite care facilities for adults (settings registered as care homes)

Stand-alone residential respite facilities for adults in settings registered as care homes should continue to follow this guidance, COVID-19 Guidance and Information for Care Home Settings, using a risk assessment approach in support of each admission, as outlined previously in **Section 7.3** of this guidance.

A risk assessment is advised prior to admission, to determine whether the individual's care needs mean they should be isolated for the duration of their stay (or for 14 days from admission) or not; and whether any specific enhanced infection prevention and control measures are needed.

All admissions from the community (including admissions from other care homes and hospices) should have one negative PCR test returned within 3 days of their admission date. In exceptional circumstances where testing is not possible before admission then testing on admission to the care home is acceptable. Where it is in the clinical interest of the resident and PCR testing is not feasible (e.g. resident does not consent, detrimental consequences or it would cause distress), an agreed care plan for admission to the care home will document this. Advice on this process is available from the local Health Protection Team, if needed.

Residents who are admitted to the care home for residential respite are encouraged to maintain physical distancing from other residents. Care home staff should risk assess this.

The respite advice included in the **COVID-19: information and guidance for social, community and residential settings** should be followed for:

- Individuals accessing respite in settings that are not a registered care home
- Residential respite facilities for children (including those registered as care homes)

If a facility does not fall into these categories or is unsure about which guidance applies, they can approach their local HPT who will advise based on the characteristics of the home.

8. Staff Information

8.1 Visiting professionals to care homes

- As outlined in the **Scottish Government letter published in December 2021**, professional visits to the care home should continue to be supported as these can be essential to wellbeing. It is important that visits by services / professionals are

coordinated (e.g. planned in advance) with care homes to manage footfall and minimise burden and risks on the care home population.

- Regular testing of asymptomatic visiting staff is advised using **LFD tests**.
    - Testing programmes for visiting professionals (health and social care professionals) are organised through their employers. Verbal confirmation of a negative LFD test within the last 72 hours from health and social care professionals who participate in such testing is acceptable. The absence of testing is not a barrier to providing necessary clinical care in person - as long as appropriate **IPC measures** (including on PPE) are followed.
    - Other visiting staff, such as maintenance staff, private podiatrists, hairdressers, etc., who may not be offered testing through their employers are encouraged to undertake an LFD test at the care home. Some of these professionals may visit several care homes in a day or across several days, therefore, it is recommended that they test twice weekly under the universal LFD offer. They do not need to be tested in each care home they attend.
- Visiting clinical staff should be supported to attend in person for essential clinical assessments and treatment of residents where this clinically indicated. Methods such as telephone and telemedicine remain useful and important ways to provide aspects of care, however for some residents, clinical care and assessment provided in person may be more appropriate. Care will be needs-led and wherever feasible, aim for a renewed focus on anticipatory, preventative and rehabilitative care for all residents.
- Such visiting professionals do not require SARS-CoV-2 (coronavirus) PCR screening for each visit, though regular symptom vigilance checks and LFD testing are useful to have in place. All visiting staff are expected to follow the COVID-19 guidance and all control measures implemented in the care home, in particular:
    - All visitors, organisations and professionals should wear a Fluid Resistant (Type IIR) Surgical Mask (FRSM) and maintain at least 1 metre or more physical distancing where possible, unless closer contact is necessary for the provision of care.

- If the visit requires direct contact, additional PPE may be required in accordance with **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum**

- The use of bank or agency staff or clinical staff from other care homes or healthcare services as replacement staff should be minimised, especially during outbreaks when they should only work for one care home at a time. Measures should be taken to support this wherever possible, to reduce the risk of transmission between care homes. If the use of bank or agency or clinical staff from other care homes or healthcare services is considered necessary for maintaining safe operation of the care home, then documentation of a risk assessment is expected. Any new staff starting work in the care home are also subject to SARS-CoV-2 (coronavirus) PCR screening. See **section 8.7** for further details.

- During an outbreak, the deployment of clinical staff from other care homes or healthcare services to replace ill or self-isolating staff must be carefully considered, at the discretion of the local HPT managing the outbreak in collaboration with care home management. Visits from non-clinical services are also likely to cease temporarily unless deemed essential, on advice of the local HPT.

8.2 Enabling staff to follow key measures described in this guidance to prevent viral spread

Ensure that all staff in the care home are aware of the requirement to follow guidance for COVID-19 and are supported to do so. Consider the additional demands that will be placed on staffing requirements and plan ahead (resilience planning) to support this. Additional demands may occur due to:

- time required for weekly staff screening

- additional time required to facilitate good **IPC measures** (including good hand hygiene, **PPE** use and **staff cohorting**), **training** and general guidance review

- staff self-isolating as a case or as a contact in the workplace or community

- Scottish Government **COVID-19: social care staff support fund guidance** aims to ensure social care workers do not experience financial hardship if they are ill or self-isolating due to COVID-19 and their employer terms and conditions mean a reduction in income.

Caution is needed regarding employees in health and care settings socialising outside the workplace, and the risk associated with this should be assessed, particularly for small care homes, where resilience arrangements may be at high risk. Avoiding such events is advised this season. **Lateral flow testing should** be done before attending social events. Individuals with a positive test result must self-isolate and arrange a confirmatory PCR test.

8.3 Staff who have been identified as COVID-19 contacts

Care home staff must inform their manager if they have been identified as a household or close contact of a COVID-19 case. They must begin **self-isolation** and **arrange to be PCR tested**.

All staff should be vigilant for COVID-19 symptoms at all times, but particularly during the incubation period following exposure (up to 14 days) to someone infected. If staff develop symptoms they must stay at home and follow advice from **NHS inform** or occupational health department as per the local policy for symptomatic testing.

Staff who come into contact with a COVID-19 resident, another staff member or any individual with COVID-19 whilst at work require risk assessment to ascertain whether appropriate **infection prevention and control measures** were followed during that potential exposure. The measures expected include practising good hand hygiene, not working with COVID-19 cardinal symptoms, wearing relevant personal protective equipment (PPE), physical distancing whenever possible. If such measures were followed satisfactorily, they may not need to self-isolate from work. Test and Protect and the local HPT can assist with such risk assessments.

As applicable to the **general population**, care home staff may also be exempt from self-isolation in their non-working lives, if identified as a non-household contact, when the following conditions must be met:

- fully vaccinated with a UK-**approved vaccine** from at least 14 days prior to the date the contact took place (note, day 1 is the day of final dose of the vaccine schedule). This currently requires 2 doses and the booster dose,
- not currently self-isolating as a case or a contact or for travel-related reasons
- remain asymptomatic
- not been advised to continue to isolate for any other reason by Test and Protect or a HPT
- have a negative PCR test after exposure to the case
    - The test should be taken any time after the contact occurred; or in the case of ongoing contact e.g. a household member, on or after their symptom onset date or test date in asymptomatic cases
    - Those with recent PCR confirmed infection (in the last 90 days) need a further PCR as a condition of exemption.

However, due to the potential spread to vulnerable people, additional mitigations are required for health and social care staff returning to work within their isolation exemption period. See **Winter Response - self-isolation of social care staff**, which sets out these requirements, and are summarised below:

- Full vaccination status for health and social care workers (HSCW) refers to primary course and booster at least 14 days prior to exposure
- Daily LFD tests are required for 10 days following last exposure:
    - If the COVID-19 case is a household member, for 10 days from the date of symptom onset, or test date if household member is asymptomatic.
    - If a contact is exempt from the initial PCR test due to a positive PCR in the previous 90 days, a negative LFD is required before return to work and daily LFDs must still be done.

    - Each staff member must register the results of the daily LFD online and inform their manager. Adherence and reporting of daily LFD tests should be supervised by the line manager of the staff member.

- If any of the daily LFD results are positive, the staff member must isolate and seek a confirmatory PCR, even if they have had a positive PCR result in the previous 90 days, in order to support further risk assessment.

Eligibility for the contact self-isolation exemption is not available in certain circumstances. **Test and Protect or the local HPT will advise.**

HSCW who are medically exempt from vaccination are not eligible for this exemption from contact self-isolation, nor are HSCWs under 18 years of age who are unvaccinated.

Similar to those who have been vaccinated with approved vaccines, staff (identified as close contacts) who are participating / have participated in a COVID-19 vaccine clinical trial should only be permitted to return to work following an individual risk assessment. Support for more complex risk assessment may be provided by the local Occupational Health, IPC or HPT if required.

Care home staff who have been identified as contacts are in any case advised to limit contact with others in line with the COVID-19 mitigation advice issued to the general population during their isolation exemption period. Care home staff must adhere to IPC measures and PPE should be worn in accordance with the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum**. FRSMs are required to be worn at all times during the working day except when eating or drinking.

Where a staff member declines daily LFD testing then they should not work in any health and social care setting during their contact self-isolation exemption period, whether resident facing or not.

Health and social care services no longer need to demonstrate that they are in an 'in extremis' position before asking staff to return to work. Responsibility for ensuring the guidance is implemented lies with the employer/line manager.

In certain situations, the local HPT can override exemptions from close contact isolation and staff may be required to self-isolate for 10 days. For example, during an outbreak or following the identification of a new variant of SARS-CoV-2 virus.

Where conditions cannot be fulfilled for exemption from self-isolation as a contact, the staff member must not attend for work and is expected to complete self-isolation for 10 days following exposure.

If a staff member becomes symptomatic whilst self-isolating as a contact or during their contact isolation exemption period, they must self-isolate and arrange for a PCR test as soon as possible, even if they recently tested PCR negative. If the staff member tests PCR positive, they must self-isolate for 10 days from the date of symptom onset and their household members should follow the '**stay at home**' advice and **arrange to be tested**. The conditions that apply to the general population to shorten a period of self-isolation if identified as a contact also apply to household members of staff – see **NHS inform**.

8.4 Staff Testing

Anyone in Scotland who has symptoms of COVID-19 is **eligible** for testing through UK Government Testing sites. However, testing pathways for symptomatic health and care staff can vary across health board areas - this can be discussed with the local HPT. It is usually possible to prioritise appointments for **key workers** and their household members. Further information is available on **NHS inform**. If a symptomatic staff member has a positive PCR test – advise the local HPT and see information in **Table 2** for further details.

Staff screening using PCR testing - weekly

Weekly care home staff PCR screening for COVID-19 remains in place whether staff are fully vaccinated or not. This weekly PCR testing is now processed through Regional Hubs. Care home staff should use the COVID testing portal - see **www.covidtestingportal.scot** to arrange this. See **section 4** for more information.

Staff screening using Lateral Flow Device (LFD) testing - daily

Daily LFD tests (working days) for asymptomatic care home staff are to be used alongside the existing weekly PCR test, from 10th December, with the advent of the Omicron variant of SARS-CoV-2, as outlined in the Scottish Government's **COVID-19: minimising the risk over winter and updated protective measures for Omicron variant** letter. If any LFD test is positive, the member of staff should self-isolate and await the PCR result to confirm. If the PCR test is positive, they must remain isolated. If the LFD test is positive and the PCR test result is negative, a risk assessment should be undertaken by the local HPT to determine if contact tracing should be reversed and if the staff member can end self-isolation. This risk assessment prior to ending self-isolation following negative PCR result is particularly important for care home staff given the care home is a high risk setting.

See the **'Update for Adult Care Homes on testing for Staff and Visitors'** from 13 July 2021 for more information, which outlines that the second weekly LFD test can be done by staff at the care home's discretion.

Symptomatic staff should not use LFD tests and must not attend work. This is because these tests have not been approved by the MHRA (the regulator) for symptomatic testing, but for asymptomatic testing. With LFDs there is an important false negative proportion, where someone with symptoms may obtain a negative result, and be falsely reassured, yet still be infectious. Symptomatic staff can access a PCR test as per usual channels within their Board. On the occasion that a symptomatic staff member has used a LFD test and has returned a negative result, they should still self-isolate and arrange a PCR test.

Additionally, asymptomatic staff who are negative on LFD testing must not regard themselves as free from infection – the test could be a false negative – they may go on to develop the infection in the period before the next test. Although they can continue to work, they should remain vigilant to the development of symptoms and existing **Infection Prevention and Control (IPC) measures** must be followed. This includes following physical distancing measures at all times in the workplace where possible.

Additional testing considerations - 90 days issue

In light of Omicron's increased transmissibility, repeat testing within 90 days of a laboratory-confirmed COVID-19 diagnosis is now advised, when contact testing is indicated. This is especially important when the individual is symptomatic, whether they have been identified as a contact or not. If the test result is positive by LFD or PCR, the individual must self-isolate and a risk assessment may be required to determine further actions. This can be supported by the local HPT.

Routine screening by weekly PCR and now daily (working days) LFDs remains unchanged for those who have tested PCR positive in the previous 90 days: no weekly PCR is required but daily LFDs should continue.

Repeat positive tests (asymptomatic or symptomatic) **after** 90 days should result in the usual public health action, i.e. self-isolation of the person with the positive test and contact tracing.

8.5 Management of PCR test positive staff through weekly screening programme

Staff who test PCR positive for COVID-19 through weekly screening should follow actions detailed in **Table 2**. If there is low pre-test probability (e.g. asymptomatic, no close contact status, no recent travel), a repeat test may be indicated.

Table 2. Summary of actions in response to PCR test positive in care home staff

Response to PCR positive test result in care home staff
Staff may continue to work whilst awaiting weekly test results providing they: • remain asymptomatic and • apply stringent IPC measures as per COVID-19 IPC guidance while working • self-isolate if LFD test has also been done and is positive, until PCR confirmatory test is available If the PCR test result is equivocal or unclear, the test must be repeated ASAP. If negative, the staff member can continue to work but, must be hyper-vigilant for the development of any symptoms. If the repeat PCR test result is positive, treat as a positive symptomatic case and undertake appropriate contact tracing with HPT – see **here** for further information. The care worker must self-isolate for 10 days from the date of the test. If they become symptomatic during their 10-day isolation period, they can return to work: • no earlier than 10 days from symptom onset, provided clinical improvement has occurred and they have been apyrexial for 48 hours (without use of anti-pyretics). • if the only persistent symptoms after 10 days are a cough (post-viral cough known to persist for several weeks in some cases) or a loss or change in normal sense of taste or smell, then provided they are otherwise medically fit, they can return to work. • no clearance or repeat testing is required (see **section 8.4** for testing advice following confirmed COVID-19 infection) • providing they continue to maintain **IPC measures** Household contacts of the care worker must follow **'stay at home'** advice and **arrange to be tested**. An exemption to **self-isolation** or shortening a period of isolation may apply. See **here** for more information.

Delayed exclusion of PCR test positive care home staff for those identified through weekly screening

There might be rare circumstances where there could be an unavoidable delay in replacing all test positive staff immediately during investigation of an outbreak. This could create an unacceptable risk to the safety of residents and the care being provided. If such a situation occurred, then any staff that had to continue working must only do so for the

absolute minimum period (e.g. to complete a shift) pending their replacement, as agreed with the HPT leading the management of the outbreak. Such staff would only be permitted to work if they:

- remain asymptomatic and maintain vigilance for any COVID-19 symptoms and leave the workplace if they develop symptoms
- continue to maintain **IPC measures** (as they would have been doing in the days prior to their test result being known)
- only work with residents already known to be infected themselves
- maintain appropriate physical distancing when a mask has to be removed
- eat or drink in a separate room, either on their own or only in the company of other test positive staff
- avoid unnecessary casual contacts and observe appropriate physical distancing when heading home, avoiding if possible or limiting the use of public transport or car-sharing with people they do not live with.

8.6 New staff in the care home (including replacement of excluded staff)

Any new or agency staff coming into a care home, must be screened for current symptoms consistent with COVID-19 infection and require a recent PCR negative test result, ideally before their planned start date **and** no longer than 48 hours before, whether the care home is affected by an outbreak or not.

If a prospective new care home worker is **symptomatic** on pre-work screening, they must not start work at any care home. They must ensure their symptoms are investigated for COVID-19 before starting. If any new or agency staff assigned to the care home are PCR test positive, follow the details in **Table 2** on managing PCR test positive staff.

Delays in testing new care home staff

If there is likely to be a significant delay in organising PCR testing and if there is a critical shortage of staff who are known to be test negative, then an **asymptomatic** new care home worker should take a LFD test before starting. If the LFD test is negative, the staff member may be permitted to work at an outbreak affected care home, but only if they **remain asymptomatic**. The care home manager must be in agreement.

They must however be PCR tested **as soon as possible**. While working in the affected care home, the care worker awaiting the test result should minimise their direct contact with residents who are asymptomatic, whilst applying all **IPC measures.**

If the LFD test is positive, the staff member must not start work in the care home and should return home immediately to self-isolate and arrange a confirmatory PCR test.

8.7 Staff uniforms

It is safe to launder uniforms at home. If the uniform is changed before leaving work, then transport this home in a disposable plastic bag. If wearing a uniform to and from work, then change as soon as possible when returning home.

- Uniforms should be laundered daily, and:
- separately from other household linen;
- in a load not more than half the machine capacity;
- at the maximum temperature the fabric can tolerate, then ironed or tumble dried.

Scottish Government uniform, dress code and laundering policy is available.

9. Visiting arrangements for family and friends

9.1 Routine visiting advice

The Scottish Government's published guidance, **Open with Care: supporting meaningful contact in care homes**, supports the continuation of meaningful contact between care home residents and their loved ones through visiting. It also includes information on outward visits from the care home - see **section 7.4** of this guidance for more details on visits away from the care home.

The offer of asymptomatic testing of visitors to adult care homes remains in place as an option - see the Scottish Government **COVID-19: adult care home lateral flow device testing** for further information. Scottish Government **advice issued on 13 July 2021** also provides for family and friends visiting care homes, to test at home (or away from the care home) before visits. It includes training materials for care home staff, useful resources (e.g. posters) and information for visitors. Information for visiting family and friends is also available on **NHS inform**. Children aged 12 and over are recommended to undertake an LFD test either before arriving at the home or at the home; however this is not obligatory. Parental consent should be sought before any test, though children's views must be considered. Children should not attend visiting if they are unwell.

Although there are no limits on how often residents can receive visitors in the care home or the number of visitors a resident can have present at any one time, visiting must remain manageable for care home staff and the resident themselves. The group size of family and friend visitors should be risk assessed by care home staff to determine the number of visitors (including children) that a resident can have at any one time. The assessment should consider the built environment of the care home, including factors such as ventilation and size of the area where visiting will occur.

Visitors may have touch contact with loved ones (hug/kiss) however are reminded that maintaining 1 metre or more distancing outwith direct touch contact wherever possible will help reduce the risk of transmission of COVID-19 and other respiratory pathogens to them, their loved one and others in the care setting. It is important to note that prolonged close contact between individuals increases the risk of virus transmission even when no symptoms are evident and people are vaccinated. Visitors are asked to avoid circulating

around the care home unnecessarily and should remain in the room of the resident who they are visiting.

On 14 December 2021, the First Minister announced additional guidance for the general public regarding socialising at home or in public places, in response to the appearance of the Omicron variant of SARS-CoV-2, as the festive season approaches. **The Scottish Government** subsequently wrote out to adult care homes to inform of the temporary measures that are recommended to be taken to support this guidance, see **COVID-19: minimising the risk over winter and updated protective measures for Omicron variant**. These communications include a recommendation that care home visits should be limited to two households at a time per resident and that all protective measures are maintained.

Groups of external visitors, including community groups (e.g. school children, choirs) are still not permitted inside the care home. External visiting groups may perform outdoors in the care home grounds where residents can observe from a window inside the care home (e.g. window choirs). The care home manager should risk assess the feasibility of such visits by external visiting groups.

Visitors must not attend the care home with COVID-19 symptoms or before a period of self-isolation has ended, whether identified as a case of COVID-19 or as a contact. If a visitor has met the conditions for contact self-isolation exemption to shorten their 10-day self-isolation period as a non-household close contact in the community, they should postpone visiting a care home during this time (exceptions can be made for essential visits). Visitors must be informed of and adhere to IPC measures in place, including face coverings, hand hygiene and physical distancing, whenever feasible.

A log of all visitors should be kept, which may be used for **Test and Protect** purposes. Vaccination is encouraged for all visitors but is not obligatory. See the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum** for further IPC information in relation to visitors.

Individuals who are self-isolating due to **international travel** regulations should not visit the care home during their self-isolation period and attending a care home in the subsequent 10 days after return from a red-list country is not permitted, unless through special dispensation under travel regulations for end-of-life visits.

9.2 Visiting arrangements when residents are self-isolating

Residents who are self-isolating as a **contact of a COVID-19 case,** for **international travel** purposes, or for **admission purposes,** e.g. admitted to the care home from hospital or other setting, can receive one visitor per day in their private room during their isolation period. The visitor should adhere to IPC measures and only enter the residents' private room, avoiding other areas of the care home, and minimising time spent passing through corridors as much as possible. The visitor cannot be a contact or case themselves during the period they are visiting.

If a resident who is self-isolating has tested positive for COVID-19 or has **symptoms** consistent with COVID-19 infection, visiting can take place only following a risk assessment by the care home team. If a care home outbreak has been declared by the local HPT, then the advice in the **section 9.3** should be followed instead.

9.3 Visiting arrangements during an outbreak

When an outbreak is declared by the local HPT, routine visiting is likely to be suspended. A framework is now in place, **COVID-19: named visitor during outbreaks - letter and guidance for care home sector**, whereby care homes can support residents to choose a named visitor who may visit the resident in their private room during a COVID-19 outbreak if the local HPT has agreed this can happen.

The outbreak management process is at the discretion of the local HPT, led by an appointed competent person under the **Public Health Etc. (Scotland) Act 2008**. Outbreak management in a care home follows a dynamic risk assessment approach led by the Health Protection Team, often via the incident management team (IMT) whereby the situation is continuously assessed and the control measures reviewed. At any point during the outbreak, visits by the named visitor may be temporarily suspended to all but essential visits to enable the outbreak to be brought under control.

It is important to note that enabling the opportunity for each resident to have a named visitor during an outbreak in the care home carries a degree of risk. Care homes still remain vulnerable settings due to the nature of communal living and the vulnerability of the resident population. PPE is needed to protect the visitor also. However, having a named

person to visit during a managed COVID-19 outbreak can avoid residents experiencing prolonged periods of isolation from their loved ones and recognises the benefits to resident's health and wellbeing this may have.

A minimum of 14 days must elapse from the last exposure to SARS-CoV-2 before an outbreak can be declared over. The HPT must also be satisfied that infection prevention and control measures are in place and operating well before the care home can fully re-open to routine visiting. It is not possible to specifically define a 'controlled' situation - all care home outbreaks are challenging and dynamic.

The Scottish Government's **COVID-19: named visitor during outbreaks - letter and guidance for care home sector** highlights the importance of adhering to this guidance for care home visiting.

The following points provide an outline for this initiative of the 'named visitor':

  - providers should support residents to nominate their named visitor and keep an updated record of each resident's named visitor. They should involve family members, friends and advocates in this task, as appropriate

  - during an outbreak, the named visitor should ideally remain the same person and visiting is restricted to the resident in their own room.

  - in the event the named visitor cannot visit (e.g. they are-self-isolating, on leave, ill), the care home should discuss and facilitate an alternative individual that can act as the named visitor. Frequent changes in named visitor are not workable for this initiative.

- Visitor eligibility for a named visitor includes:

  - the named visitor is asymptomatic and not known to be COVID-positive.

  - the named visitor has not been identified as a case or a close contact of a COVID-19 case in the previous 14 days.

  - the named visitor is strongly encouraged to be fully vaccinated, defined as having received the full course of an MHRA approved vaccination, with 14 days having elapsed since the final dose.

- the named visitor adheres to COVID-19 precautions such as LFD testing and wearing an FRSM mask (and other PPE if advised), and physical distancing (as advised in the **Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum**).

- the named visitor is made aware and understands the risks to themselves in visiting during an outbreak, to the resident and the other residents and staff of the care home as a setting of communal living.

- a named visitor can visit a COVID-19 positive resident who may require some comfort in what can be a stressful time. This would require the local HPT's involvement in risk assessing whether this very managed visit could be supported, considering the resident's needs and the nature of the outbreak at that time.

- named visitors may, with agreement of the resident (or representative) and the care home manager, provide day to day basic care to support residents' health and wellbeing. This is complementary to the care from staff and might for example include encouragement to eat and drink.

    - as care homes have a range of additional tasks to care for and protect all residents during an outbreak, relatives and care home staff are asked to work together to support named visitors on factors such as the time and length of visits.

- the local Health and Social Partnership Oversight Team working alongside the local HPT have a role in supporting care homes to implement the approach and in monitoring implementation of the named visitor initiative.

Regardless of outbreak status, efforts will continue to be made to enable visits of loved ones of a resident receiving end of life care. Other essential visits for consideration can include providing support to someone with a mental health issue, a learning disability or autism where not being present would cause the resident to be distressed. The Scottish Government have produced a quick guide on a wider definition of essential visiting - available **here**. However, during an outbreak, conditions by which such essential visits continue are under regular review by the HPT or IMT managing the outbreak.

9.4 Day services in care homes

Some care homes host day services for people in shared facilities within the home. These services generally provide varied, stimulating activities, companionship and care but were suspended at the start of the pandemic. The Scottish Government issued advice on 15 July 2021 indicating that day services which operate in a care home site should be supported to resume, once the necessary planning and preparations have been undertaken, including a risk assessment of the impact of the service on the care home and its residents. Such risk assessments should be reviewed regularly.

Although testing is not required before attendance, individuals attending day services in care homes are expected to maintain a 1 metre physical distance, where possible, as this will reduce the risk of viral transmission between service users who do not normally reside together. This also applies to staff working at these services when they are situated within care home settings. If an outbreak is declared by the local HPT, the service will be temporarily suspended.

Guidance on adult building based day care services can be found **here**.

10. Death Certification during COVID-19 pandemic

According to the CMO letter dated 20th May 2020 “Updated Guidance to Medical Practitioners for Death Certification during the COVID-19 Pandemic" from 21st May 2020, any death due to COVID-19 or presumed COVID-19 meeting the following conditions must be reported to the Procurator Fiscal under section 3(g) of the **Reporting Deaths to the Procurator Fiscal guidance**.

- where the deceased was resident in a care home (this includes residential homes for adults, the elderly and children) when the virus was contracted
- where to the best of the certifying doctor’s knowledge, there are reasonable grounds to suspect that the deceased may have contracted the virus in the course of their employment or occupation

Deaths as a result of presumed COVID-19 disease in the community are not required to be reported to the local HPT.

The Death Certification Review Service (DCRS) will continue to provide advice via their enquiry line on 0300 123 1898 or **dcrs@nhs24.scot.nhs.uk** and authorise disposal of repatriations to Scotland.

Appendices

Appendix 1 – Contact details for local Health Protection Teams

Up to date information on contact details for local Health Protection Teams is available **here**.

Appendix 2 - Self-isolation period for cases and contacts

Table 1a: Self-isolation periods for cases and contacts - care home settings

Case or Contact	Staff or Residents	Self-isolation period (days) *
COVID-19 cases	Residents	14
COVID-19 cases	Staff	10
Close contacts of cases	Residents	14
Close contacts of cases	Staff**	10

Table 1b: Self-isolation periods for cases and contacts - health and social care settings

Case or Contact	Staff or Residents	Self-isolation period (days) *
COVID-19 cases	In-patients (case) remaining in the hospital	14
COVID-19 cases	In-patients (case) discharged to older adult residential setting	14
COVID-19 cases	In-patients (case) discharged to residential setting other than older adult	14
COVID-19 cases	In-patients (case) discharged to own home	14
COVID-19 cases	Staff	10
Close contacts of cases	In-patients (contact) remaining in the hospital	14
Close contacts of cases	In-patients (contact) discharged to older adult residential setting	14
Close contacts of cases	In-patients (contact) discharged to residential setting other than older adult	Requires risk assessment with regards to 10 or 14 days
Close contacts of cases	In-patients (contact) discharged to own home	10
Close contacts of cases	Staff**	10

Table 1c: Self-isolation periods for cases and contacts - prisons/custody settings

Case or Contact	Staff or Residents	Self-isolation period (days)*
COVID-19 cases	People in prisons/custody settings	10
COVID-19 cases	Staff in prisons/custody settings	10
Close contacts of cases	People in prisons/custody settings	10
Close contacts of cases	Staff in prisons/custody settings***	10

Table 1d: Self-isolation periods for cases and contacts - general public

Case or Contact	Self-isolation period (days) *
COVID-19 cases	10
Close contacts of cases	10***

Table 1e: Self-isolation periods for cases and contacts - returning travellers

Case or Contact	Self-isolation period (days) ****
Traveller arriving in Scotland via air travel from outside the common travel area *	For managed quarantine (red-listed countries): 10 days self-isolation counting day 0 is considered day of arrival in Scotland For home isolation (non-red-listed countries): 10 days self-isolation with day 0 the date of departure from or transit through the non-exempt country* is required for those without fully recognised vaccination. For fully vaccinated travellers (from non-red-listed countries), home isolation is required until a negative test result from day 2 PCR test. Valid vaccines are those accepted by the UK regulatory authorities.

Additional notes

1. For cases, Day 1 of isolation is the first day of symptoms (or the date that a positive test was taken, if asymptomatic); travel regulations manage days of isolation differently

2. For close contacts, Day 1 of isolation is the last day exposure occurred (with a COVID-19 confirmed case)

3. *Isolation ends at 23h59 on the 10th or 14th (as appropriate) day of isolation

4. ****For travellers who are required to enter **isolation for quarantine purposes**:

a) where isolation is in a Managed Quarantine Facility (MQF) (for travellers from red-listed countries) then Day 1 is established in Scottish regulations and relates to the day after arrival in Scotland, where the traveller has travelled in a non-exempt country in the previous 10 days

b) where isolation is at home (for travellers from non-red-listed countries) then Day 1 is established in Scottish regulations and relates to the day after departure from a non-exempt country.

In both cases, regulations require that for any positive test result, the traveller should remain in isolation until the end of the 10th day after the test was taken. If the traveller's Day 2 test result is positive there is no requirement to submit a second test on Day 8 (if Day 8 test required).

*These are minimum isolation periods and should be extended in line with guidance if the following apply prior to the end of the stated isolation period:

- a case has not recovered (e.g. is still not well and has not had a fever-free period for 48 hours without anti-pyretics)
- a close contact develops symptoms or has a positive COVID test result
- a case testing positive whilst asymptomatic who then develops symptoms within the isolation period
- a returned traveller develops symptoms during the quarantine/isolation period

- considerations made by an Incident Management Team in the course of an outbreak

** Self-isolation is required for ALL close contacts, however health and social care staff may be exempt from contact self-isolation, if certain conditions are met (e.g. asymptomatic, doubly vaccinated, COVID testing negative) – see **section 8.3** and **NHS inform**. The days outlined in column relate to default self-isolation timeframe, if conditions do not apply.

***Self-isolation is required for ALL close contacts, however, self-isolation can be shortened for contacts in the general population who meet certain criteria – see **Scottish Government COVID-19 staying safe and protecting others guidance** and **NHS inform** for details.

****Please see **COVID-19: guidance for Health Protection Teams** and **COVID-19: international travel and managed isolation (quarantine) guidance** for further details about quarantine requirements, exemptions and defensible reasons for breaching quarantine regulations.

References

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