COVID-19 Guidance for Healthcare Settings

Public health guidance

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0131 314 5300
phs.otherformats@phs.scot
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<td>AGPs</td>
<td>Aerosol generating procedures</td>
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<td>ARHAI</td>
<td>Antimicrobial Resistance and Healthcare Associated Infection</td>
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<td>CACs</td>
<td>COVID-19 Assessment Centres</td>
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<td>CMO</td>
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<td>COVID-19</td>
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<td>FFP3</td>
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<td>FRSM</td>
<td>Fluid resistant surgical mask</td>
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<td>HCP</td>
<td>Healthcare professional</td>
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<td>Health protection team</td>
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<td>HSCW</td>
<td>Health and social care worker</td>
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<td>IMT</td>
<td>Incident management team</td>
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<td>JCVI</td>
<td>Joint Committee for Vaccines and Immunisation</td>
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<td>LFD</td>
<td>Lateral flow device</td>
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<td>MHRA</td>
<td>Medicines and Healthcare Products Regulatory Agency</td>
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<td>MQF</td>
<td>Managed quarantine facility</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NIPCM</td>
<td>National Infection Prevention and Control Manual</td>
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<td>NSS</td>
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<td>OHS</td>
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PCR  Polymerase chain reaction
PHE  Public Health England
PHS  Public Health Scotland
PPE  Personal protective equipment
RNA  Ribonucleic acid
RSV  Respiratory syncytial virus
SARS-CoV-2  Severe acute respiratory syndrome coronavirus 2
SAS  Scottish Ambulance Service
SDCEP  Scottish Dental Clinical Effectiveness Programme
SIGN  Scottish Intercollegiate Guidelines Network
SIREN  SARS-CoV-2 Immunity and Reinfection Evaluation
STAC  Scottish Terms and Conditions Committee
UKHSA  UK Health Security Agency (formerly PHE)
VAMs  Variants and mutations
1. Scope of the guidance

This guidance has been prepared for healthcare settings providing core services during the Coronavirus disease 19 (COVID-19) pandemic.

- **Section 4** covers the core public health principles and measures for managing COVID-19 that apply in most healthcare settings.

- **Section 5** provides additional information for specified healthcare settings. Settings included are primary care (including healthcare delivered in the community), secondary care (i.e. hospitals), hospice care and ambulance settings.

The guidance document will continue to be revised in response to the changing nature of the pandemic. 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.

This guidance does not seek to duplicate other Scottish guidance documents published elsewhere. It has instead linked to other sources of guidance, as additional relevant sources, though Public Health Scotland (PHS) are not responsible for the content of external sites or guidance.

Advice for social, community and residential care, care home settings and Health Protection Teams can be found at the PHS Guidance specific for those settings. Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland leads on matters of Infection and Prevention Control - please see further information in section 2.1.

Further details on COVID-19 and the Scottish response can be found on the Scottish Government website and National Health Service (NHS) inform. Clinical guidance on COVID-19 is published by Scottish Intercollegiate Guidelines Network (SIGN).
2. Introduction

The disease COVID-19 is caused by an RNA (ribonucleic acid) virus, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). 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.

Transmission of SARS-CoV-2 mainly occurs through close contact with an infectious individual, mediated by respiratory particles, also known as droplet transmission. 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. 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.

It is useful to note the cardinal symptoms of COVID-19 are new, continuous cough, fever or change in or absence of sense of smell or taste (as outlined in section 3). 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 complications. Mortality is an unfortunate potential outcome in those with severe disease. There is evidence of asymptomatic transmission of COVID-19.

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. WHO advises the average incubation period is between 5-6 days, however it can range from 1-14 days.

After being infected with SARS-CoV-2, most people recover quickly, usually starting to feel better in a few days; unfortunately, some people take longer and symptoms can affect the whole body. SIGN has produced a booklet for anyone with ongoing signs and symptoms of COVID-19 and NHS inform provides a variety of useful information.
PHS provides a daily updated **dashboard** with the latest available data including, but not limited to, the numbers of positive cases reported, the number of tests carried out, the number of vaccinations administered and percentage of Scotland's population who are vaccinated.

All viruses change through mutation; the term "variants and mutations" (VAMs) describes a group of selected SARS-CoV-2 variants and mutations that are predicted to be responsible for the changes in properties of the virus. VAMs are the result of natural changes that happen when viruses transmit between people. They are maintained within a population when they provide some advantage to the virus. These advantages include increased transmission, virulence and immune escape. Due to the potential for future VAMs to circumvent current mitigation measures through improved transmissibility, pathology or immune escape, practitioners should be cautious that public health mitigations, including vaccination, may require future re-evaluation.

**2.1 National Infection Prevention and Control Manual addenda**

PHS works in close collaboration with ARHAI Scotland on aspects related to Infection Prevention and Control (IPC). ARHAI Scotland are part of NHS National Services Scotland (NSS) and provide evidence-based guidance, surveillance and expert advice. The NHS Scotland National Infection Prevention and Control Manual (NIPCM) was first published in January 2012, by the Chief Nursing Officer (CNO (2012)1), and updated in May 2012 (CNO(2012)01-update). As an evidence-based resource it is intended to be used by those involved in health and care provision. The NIPCM is mandatory across NHS Scotland and care homes and contains a wide range of IPC advice on one platform including the COVID-19 IPC addenda. This PHS guidance should be read in conjunction with the relevant NIPCM addenda:

- **Scottish COVID-19 Community Health and Care Settings Infection Prevention and Control Addendum** is for use in primary care and community care settings;

- **Scottish COVID-19 Infection Prevention and Control Addendum for Acute Settings** is for use in secondary care settings.

There is also a **Scottish COVID-19 Care Home Infection Prevention and Control Addendum** available that provides guidance for care home staff and providers.
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 will supersede the three COVID-19 addenda (Community health and care settings, Acute settings, Care home) first published in October 2020. This PHS guidance document will be updated when the new IPC Guidance for Winter (2021/22), Respiratory Infections in Health and Care Settings is published for implementation in November.

2.1.1 Hospices

Hospices should refer to Scottish COVID-19 Community Health and Care Settings Infection Prevention and Control Addendum, however for patient transfers, overnight pass and bed spacing related to hospices, refer to Scottish COVID-19 Infection Prevention and Control Addendum for Acute Settings.

3. Case definition

COVID-19 cases can be classified as below. Please see the COVID-19 Guidance for Health Protection Teams for further information.

**Confirmed COVID-19 case**

A person with laboratory confirmed detection of SARS-CoV-2 by polymerase chain reaction (PCR) in a clinical specimen

**Probable COVID-19 case**

A person with a positive lateral flow device (LFD) test for COVID-19
Possible COVID-19 case

A person presenting recent onset of one or more of the following cardinal COVID-19 symptoms:

- new continuous cough
- fever / temperature ≥37.8°C
- loss of, or change in, sense of smell (anosmia) or taste (ageusia).

A wide variety of additional clinical signs and symptoms have also been associated with COVID-19. Fever may not be reported in all symptomatic people and cases may also be asymptomatic. Healthcare staff should be alert to the possibility of atypical and non-specific presentations in children, older people with frailty, those with pre-existing conditions and those who are immunocompromised. People with epidemiological links to COVID-19 outbreaks or clusters should also be considered with a high degree of suspicion. People must be assessed for other infectious or non-infectious causes of symptoms, as appropriate.

4. Guidance common for all healthcare settings

4.1 Core public health measures for all healthcare settings

This section outlines a range of measures that are recommended to reduce transmission of COVID-19. Advice on core public health measures for healthcare settings can also be found in the NIPCM addenda.

The COVID-19 pandemic is ongoing. Whilst healthcare services are moving into remobilisation and recovery, with increasing face-to-face consultations, all healthcare settings must continue to follow robust mitigation measures to reduce transmission of COVID-19 (and other infections).

Healthcare settings may have both clinical and non-clinical areas where there may be office spaces, staff rooms, and retail areas in some settings. Signage should be clearly
displayed to ensure that people are aware of and adhere to advice on measures to reduce transmission of SARS-CoV-2, e.g. the use of face masks/face coverings and physical distancing, available at [NHS Inform](https://www.nhsinform.scot).

Core measures to reduce COVID-19 include:

- Promotion of vaccination to support a high uptake. For more information on vaccination, please see [section 4.2](#).

- Check general guidance on what you can and cannot do, as this can still change in response to the pandemic situation. Consider using a flexible approach to enable staff to work from home where this is feasible. The Scottish Terms and Conditions Committee (STAC) have published guidance to support working from home: "Stay at home regulations: Working from home" (DL(2021)05) and: "Working from Home as a Consequence of COVID-19: Terms and Conditions of Service – 19 February 2021" (DL(2021)07).

- Physical distancing is an important mitigation measure to reduce transmission of SARS-CoV-2. Physical distancing of either 1 or 2 metres is required in healthcare settings, depending on the particular area. Details of this are provided in the NIPC M addenda and also in "Summary of changes to physical distancing guidance in Health and Social Care settings" which can be found in a Chief Medical Officer's Letter the Scottish Government issued on "Update to the National Infection Prevention and Control Manual COVID-19 addenda on physical distancing in Health and Social Care" (DL 2021/28). As the NIPC addenda highlight, these changes to physical distancing do not yet mean a return to pre-pandemic practices. NHS Boards and independent contractors must continue to adapt processes to ensure risk of transmission is minimised. This is the minimum guidance, further discussion with the local Infection Prevention and Control team (IPCT) / Health Protection Team (HPT) can inform this, if needed.

- Use face coverings / face masks in line with the NIPC M addenda and latest [Scottish Government guidance](https://www.nhs inform.scot). Note that face coverings are not considered to be personal protective equipment (PPE). Staff members who are exempt from wearing a face covering / face mask should discuss this with their line manager and occupational health to consider if patient-, professional- or public-facing roles are
appropriate in light of the potential risk to staff themselves or others. Exemption from wearing a face covering / face mask will be part of any workplace risk assessment.

- Follow hand hygiene and respiratory hygiene advice in the NIPCM, and also in the NIPCM addenda. Ensure that workplaces/work areas are cleaned regularly in line with advice on safe management of the care environment in the NIPCM addenda.

- Ensure that workplaces/work areas are well-ventilated. Open windows as far as temperature/weather conditions comfortably allow this. Further guidance on ventilation is available from the Health and Safety Executive (HSE) and in the NIPCM addendum.

- Engage with national testing programmes for regular asymptomatic and symptomatic testing. See section 4.3 for further advice on testing.

- Follow Test and Protect advice whenever a COVID-19 case or contact is identified linked to a workplace and support employees to follow this. Information on testing can be found on NHS Inform. The Scottish Government has also produced COVID-19: Test and Protect advice for employers. Guidance on the general approach to contact tracing and contact tracing in complex settings, including health and social care staff is available on the COVID-19 Guidance for Health Protection Teams.

- Follow the guidance to self-isolate if required. Some people may be exempted from contact self-isolation or the period of self-isolation may be shortened, based on the contact's age, vaccination status and history of recent infection. For guidance on self-isolation exemption for health and social care staff, please see section 4.5.1. Appendix 1 provides a summary of self-isolation periods for cases and contacts in different settings.

- Follow latest Scottish Government advice on international travel and managed isolation (quarantine).

- Staff (such as health care workers) with underlying health conditions that may put themselves at increased risk of severe illness from COVID-19 should discuss this with their line manager or local Occupational Health service. The Scottish Government COVID-19 Guidance on individual occupational risk assessment is available to support managers to undertake an individual occupational risk
assessment. Further information for at risk or pregnant healthcare workers can be found in Guidance for Staff and Managers on Coronavirus.

- Further advice on occupational risk assessment as well as car sharing can be found in the Scottish COVID-19 Community Health and Care Settings Infection Prevention and Control Addendum and the Scottish COVID-19 Infection Prevention and Control Addendum for Acute Settings.

- PPE exists to provide the wearer (and the people they interact with) protection against risks associated with the care task being undertaken. PPE requirements during the COVID-19 pandemic are determined by the COVID-19 care pathways/categories and are detailed in the NIPCM addenda.

- Caution is needed regarding employees in healthcare settings socialising with work teams outside the workplace, and the risk associated with this should be assessed, particularly for small departments or practices, and where resilience arrangements may be at moderate to high risk.

4.1.1 Principles for all healthcare settings

Symptom awareness and vigilance should be promoted for patients, staff, visitors and contractors who enter the healthcare premises.

Remote symptom screening is clearly not practicable in services where patients attend care premises without prior appointments. In these circumstances, there should be a local mechanism to ensure that patients entering a healthcare premises do not have COVID-19 symptoms or that if they are symptomatic, they are appropriately managed using a risk assessment approach. See section 4.6.1 and the NIPCM addenda for further information, including guidance for home visits.

4.1.1.1 Front Office/Reception/Healthcare retail spaces

- Patient facing areas should be clearly marked to support physical distancing guidance and some premises have found it useful to erect clear screens at the reception desk area. Signage should be clearly displayed to ensure that all people are aware of and adhere to the advice around the use of face masks/face coverings.
and physical distancing, available at **NHS Inform**. Consideration should be given to adopting measures to support physical distancing, e.g. by using one-way systems and minimising time spent in waiting areas.

- Patients entering the premises are required to wear a face covering (or mask), unless exempt. This does not need to be changed for a face mask on entry to the building, though provision should be available on site, if needed. Alcohol based hand rub should be available at entry to the premises.

- The patient area should be cleaned on a regular basis paying particular attention to common touch surfaces such as door handles and counter tops. Cleaning guidance is found in the **NIPCM addenda**.

### 4.1.1.2 Clinical rooms/spaces

IPC requirements are clearly outlined in the **NIPCM addenda** and include triage/screening assessment, patient placement, PPE, environmental and equipment cleaning.

Within acute settings, dental practices and other settings where aerosol-generating procedures (AGPs) are performed, there may be some limitations due to the need for post-AGP fallow time that reduces the volume of care that can be provided. Please see the **NIPCM addenda** for general information. **Section 5.1.2** gives further specific dental guidance.

### 4.1.1.3 Back Office/Communal spaces

- It is essential that standards of IPC are maintained within "staff only" areas and risk assessments undertaken for work areas that present limited spacing, e.g. meeting rooms and pharmacy workspaces.

- Outbreaks amongst staff have been associated with a lack of physical distancing in changing areas and common areas during staff breaks. It is particularly important to utilise all available rooms and spaces to allow staff to change and have rest breaks without breaching maximum occupancy in any single area. Regular local reviews of existing practice should be considered as part of the premises risk assessment to
introduce measures such as staggering staff breaks to limit the density of staff in specific areas.

- Continue to adhere to extended use of FRSMs guidance
- Keep rest and kitchen areas clean and clutter free.

### 4.2 Vaccination

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

Evidence of vaccine effectiveness across adult age groups is increasingly available. The observed reduction in both symptomatic and asymptomatic infections suggests that **vaccines licensed for use in the UK** have the potential to reduce transmission\(^5\) as well as hospitalisation, severe disease and mortality. A summary of the most recent data on real world effectiveness is published on a weekly basis as part of **COVID-19 vaccine surveillance reports** and regularly updated into the **COVID-19: the Green Book, chapter 14a**.

The Joint Committee for Vaccines and Immunisation (JCVI) provides details on the **groups prioritised for COVID-19 vaccination**. There is **evidence** of better immune response and/or protection where longer intervals between doses are used; hence the JCVI recommends a minimum interval of eight weeks between doses of the COVID-19 vaccines used in the UK, to ensure a good balance between achieving rapid and long-lasting protection. Recommended minimal intervals between doses may vary for people commencing on immunosuppressive treatment.

It is important to note that vaccination does not change the need to continue current COVID-19 mitigation measures (for both vaccinated and unvaccinated people) since vaccine effectiveness is not absolute; emphasising the following has therefore become particularly important:
• 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.

• A person’s vaccine status can alter the requirement for contact self-isolation with specific conditions applied for mitigation but compliance with IPC mitigation measures need to continue.
  
  o For the general population, being fully vaccinated can support a risk assessment approach in determining if an individual requires to self-isolate after having been identified as a close contact. Self-isolation requirements for close contacts or returning travellers may vary in certain circumstances based on setting, vaccine status or age, in particular for health and social care workers. For more details, see section 8 in the COVID-19 Guidance for Health Protection Teams.

• Vaccinated people should continue to comply with testing regimes as per unvaccinated people although there may be instances where testing varies by vaccination status (e.g. travel regulations). There is no evidence that the currently approved vaccines for use in the UK affect PCR test results for COVID-19. This may not be the case for other vaccines with different structures, as they are developed.

• It is advisable that for people who have a current diagnosis of COVID-19, vaccination is deferred for four weeks after onset of symptoms or from the first confirmed positive specimen, in those who are asymptomatic.

• Vaccination is not as 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 lack of an established evidence base on this means that the local HPT can be contacted to undertake a risk assessment in order to determine the appropriate next steps in such situations.

Suspected side effects to medicines, vaccines, or medical devices used in COVID-19 treatment should be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA) via the dedicated Coronavirus Yellow Card reporting site.
In addition, if an adverse event occurs following immunisation (either within the clinic or after the vaccinee leaves the clinic) this should be managed and reported in the usual way for the NHS board and setting by Board staff e.g. reported via Datix, Yellow Card scheme, notifications for the Care Inspectorate, and others. If the event is significant and requires rapid escalation, the clinic lead or staff member managing a person who has experienced the adverse event should contact their Board Immunisation Coordinator as soon as the event becomes apparent. Contact details of local immunisation coordinators can be obtained from local HPTs. It is a matter of professional judgement whether to report or escalate an incident, working within extant local NHS board procedures. Any uncertainty over the significance of an adverse event should be discussed with the local Board Immunisation Coordinator. If this occurs during the evenings or weekends, the local HPT out of hours service can be contacted. The contact details for local health protection teams are available here. More information on the COVID-19 vaccine is available on NHS Inform and a national helpline for the public has been set up on 0800 030 8013.

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

- Workforce education materials are available on the Turas learn site
- Leaflets explaining why the COVID-19 vaccine is being offered and how, when and where it will be given, are available on NHS inform
- Resources from PHS are available to promote the COVID-19 immunisation programme

4.3 Testing for SARS-CoV-2

There are currently various tests available for the detection of SARS-CoV-2. This section focusses on the indications for and interpretation of PCR and LFD tests only. Vaccination status does not change the relevance of such testing.

More information on testing is provided in the following guidance:

- COVID-19 guidance for sampling and laboratory investigations
- COVID-19 SARS CoV-2 virus detections testing within Scotland: a guide for non-NHS laboratories
Ideally, testing should be undertaken in the first three days of symptom onset, but can be done at any time during illness that is suspected of being COVID-19, on clinical or public health grounds.

**4.3.1 PCR testing**

Anyone in Scotland who is experiencing any of the **cardinal symptoms** of COVID-19 should be tested by PCR through UK Government testing sites or NHS labs, as organised locally. Further guidance on **eligibility** and access to testing is available on [NHS inform](https://www.nhsinform.scot) and the Scottish Government [website](https://www.gov.scot). PCR is the main diagnostic test used in Scotland in NHS laboratories and UK Government Lighthouse laboratories.

PCR testing is also recommended for certain asymptomatic people including contacts of confirmed cases, **hospital inpatients** as part of elective pre-admission processes or admission testing for unplanned admissions and as part of routine asymptomatic testing in the workplace for selected **health and social care staff working with clinically vulnerable patients**.

**4.3.2 Interpreting PCR test results**

A positive PCR test result indicates that someone is (or has been) infected with SARS-CoV-2 and needs to be managed as a **confirmed case**. See the [COVID-19 Guidance for Health Protection Teams](https://www.gov.scot) for the public health management of cases, which also addresses the issue of false positives, where repeat sampling may be advised. In some instances, a positive PCR result may reflect past infection (remnant viral RNA), but without a previous positive result, it is not possible to discern this and it may need to be managed as evidence of active infection, following risk assessment.

Everyone who has a positive PCR test result should be contact traced, unless risk assessment determines otherwise. Individuals who have previously tested positive for SARS-CoV-2 by PCR are exempt from re-testing within a period of 90 days from their initial symptom onset, or the first positive test, unless they develop new possible COVID-19 symptoms.
If an asymptomatic person is inadvertently re-tested and tests positive by LFD or PCR within 90 days of a previous positive PCR result, there is no need to do a confirmatory PCR, isolate or contact trace again, as long as the person with the repeat positive test:

- remains asymptomatic;
- is not a contact of a confirmed case;
- is not required to isolate having returned from travel to a non-exempt country;

For any case where decision-making is more complex, a risk assessment can be undertaken with the support of the local HPT, if needed.

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

However, if someone newly develops a **cardinal symptom of COVID-19** at any time, they should self-isolate and get a further PCR test.

Participants in surveillance studies (e.g. SARS-CoV-2 Immunity and Reinfection Evaluation [SIREN], Office for National Statistics [ONS] survey) will undertake regular repeat testing regardless of symptoms, in accordance with study protocols. First positive test amongst surveillance study participants should be managed in accordance with routine guidance, including isolation of the person with the positive result and contact tracing.

To address certain situations, such as in outbreaks, risk of **reinfection** with a new variant, or specific clinical or travel risks, the HPT may conduct a risk assessment and recommend action such as self-isolation or whole genome sequencing for all people testing PCR positive, without exemption.

A negative PCR result in an asymptomatic person with no known exposure suggests no infection.
4.3.3 LFD testing

LFD tests are rapid antigen tests, usually self-administered, that can be used quickly to identify asymptomatic cases with a high viral load. These tests are being widely used both at home and within workplaces and where this is happening, it is recommended that asymptomatic people test themselves twice weekly.

In healthcare settings, eligible staff are strongly encouraged to undertake asymptomatic LFD testing. See COVID-19: asymptomatic staff testing in NHS Scotland and COVID-19: getting tested in Scotland for further information.

Anyone with symptoms of COVID-19 should not use LFD tests and must access a PCR test. If a symptomatic person has had a negative or positive result using an LFD, they should self-isolate and arrange a PCR test.

More information on accessing LFD tests is available on NHS inform, and anyone without access to digital services can access LFDs from community pharmacies and their nearest COVID-19 test site.

4.3.4 Interpreting LFD test results

People who receive a positive test result from an LFD must register the result online, inform their line manager, undertake a confirmatory PCR test, and they and their household should isolate whilst awaiting the result of the PCR test. People who receive a negative LFD result must not regard themselves as free from infection – the test could be a false negative – they may still be incubating the virus and could also go on to acquire the virus in the period before the next test. Everyone must remain vigilant to the development of COVID-19 symptoms and continue to follow existing general control measures appropriate to the setting, for example IPC measures.

Rarely, repeated false positive LFD results can occur in the same person. In these circumstances, where a PCR test shows that a person does not have SARS-CoV-2, they should be advised that false positive LFD results may continue to be obtained. If LFD testing is essential, tests from a different manufacturer can be considered, although there is no guarantee that false positive results will not continue to arise.
4.3.5 Testing for respiratory pathogens other than SARS-CoV-2

Consider whether testing for pathogens other than SARS-CoV-2 such as influenza A and B, respiratory syncytial virus (RSV) and adenovirus should be undertaken in discussion with the local virologist, as necessary. This may be particularly important if testing of SARS-CoV-2 is negative during investigation of a cluster. Discussion may also be needed with the local laboratory as to whether a single swab will be sufficient, if pathogens other than SARS-CoV-2 are to be tested for.

4.4 Investigation and management of suspected reinfections

Reinfection refers to a new infection with SARS-CoV-2 following a previous PCR confirmed infection. It is distinct from persistent infection and relapse of infection. Reinfection with SARS-CoV-2 remains rare although cases occasionally occur especially in the context of high prevalence.

4.4.1 When to consider a reinfection

- A positive SARS-CoV-2 PCR test 90 days or more after a previous positive PCR test.

- New COVID-19 symptoms in a person with previous SARS-CoV-2 PCR positive infection after apparent full recovery (resolution of previous symptoms) and a positive SARS-CoV-2 PCR test (including within 90 days of a previous positive PCR test).

The COVID-19 Guidance for Health Protection Teams provides further details on the investigation and public health management of reinfection, which is beyond the scope of this guidance.

4.5 COVID-19 exposure and infection in healthcare staff

All staff should be vigilant for COVID-19 symptoms and follow national guidance for households with possible COVID-19 infection (household isolation) if they or a member
of their household has symptoms consistent with COVID-19 or a COVID-19 diagnosis (whether or not they have symptoms).

Further guidance on assessing exposure of healthcare staff and use of PPE is available in the COVID-19 Guidance for Health Protection Teams and the NIPCM addenda.

If healthcare staff are unwell, they should consider the risk to their patients, particularly those who are immunosuppressed or otherwise medically vulnerable. If there is any doubt about any risk that a member of staff may pose to patients or colleagues, this should be discussed with the staff member's line manager in the first instance. Further advice may need to be sought from the Occupational Health Department.

HPTs, Occupational Health Services (OHS) and Infection Prevention and Control teams (IPCTs) may use an algorithm contained within the NIPCM to help assess staff contacts in acute care settings.

Staff who develop symptoms and have a negative PCR test for COVID-19 should be managed in accordance with the flowchart for return to work following a COVID-19 test. Organisations and employers should monitor staff health and advise on any health and support needs.

Staff who have had confirmed COVID-19 and have since recovered must continue to follow the IPC measures, including use of appropriate PPE and completion of COVID-19 vaccination course - please see the NIPCM addenda.

Staff with confirmed/suspected COVID-19 should not return to work until symptoms resolve, with the exception of a cough and loss of/change in taste and smell, as these symptoms may persist for several weeks and are not an indication of ongoing infection when other symptoms have resolved.

Follow-up testing of staff for clearance is not generally recommended, but staff may require evidence of viral clearance prior to working with extremely vulnerable (immuno-suppressed) people. This is subject to local policy.
4.5.1 Exemption from self-isolation for health and social care staff

For health and social care workers (HSCWs) the guidance on contact self-isolation exemption for adults applies for general activities (i.e. out with the health and social care setting). HSCWs are advised to limit contact with others in line with the COVID-19 mitigation advice issued to the general population.

Due to the increased risk of potential spread to vulnerable people, additional mitigations are required for HSCW staff identified as close contacts returning to work. The Scottish Government have issued a Director’s Letter and Policy Framework on ‘Isolation Exemptions for Health and Social Care Staff’ (DL 2021 / 24) which sets out these requirements for HSCW exemption, i.e. fully vaccinated, asymptomatic and with a negative PCR test following exposure and with further mitigations:

- Daily LFD tests are required for 10 days following last exposure to the index case.
  - If the index case is a household member then for 10 days from the date of onset, or test date if the household case is asymptomatic.
  - If a contact is exempt from the initial PCR test due to a positive PCR in the previous 90 days, a LFD before return to work and daily LFDs are still required.
  - The 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 the LFD result is positive, the staff member should isolate and seek a confirmatory PCR, whether or not they have had a previous positive PCR in the last 90 days.

Staff members must adhere to infection prevention and control appropriate to the setting in which they work. PPE should be worn in accordance with the relevant guidance. Fluid resistant surgical masks (FRSMs) are required to be worn at all times during the work day except when eating or drinking. Filtering face piece (FFP3) mask use applies in AGP situations.

Where conditions cannot be fulfilled for exemption from self-isolation as a close contact, the staff member must not attend for work and is expected to complete self-isolation for 10 days following exposure. Where a staff member declines daily LFD testing then they
should not work in a health and social care setting during the isolation exemption period, whether patient facing or not.

During a period of contact isolation exemption the staff member should not work with high clinical risk patients / service users. High clinical risk groups would include patients on chemotherapy, immune-suppressants such as pre/immediately post-transplant, those who have profound immune-deficiency and other high clinical risk patients who are not vaccinated. This list is not exhaustive list and local line managers may determine other groups as fitting within the high clinical risk category. Staff can however be asked to return to work in roles to care for and support people who are not deemed at high clinical risk, if they fulfil all contact self-isolation exemption criteria.

Specifically for work in such settings, HSCWs 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 risk assessment may be provided by the local Occupational Health, IPC or HPT if required.

In an outbreak situation the local Health Protection Team can override exemption from contact self-isolation as per the Scottish Government guidance on Management of Public Health Incidents.

4.6 Patient access to clinical care

It is important that patients are able to access clinical services when indicated. This section provides guidance to maximise patient access to clinical services while minimising risks to patients, staff and to the services themselves.

4.6.1 Screening patients for COVID-19 symptoms

Many healthcare services in both primary and secondary care now operate some consultations effectively without face-to-face interaction, using a variety of methods such
as telephone, texting, emailing, calling by video or other IT interaction. This is in addition to face-to-face encounters, which occur when they are clinically indicated.

Services should screen* patients for COVID-19 symptoms and risk of exposure to COVID-19 using key questions, before attendance at healthcare settings, wherever possible. This risk assessment, and a clinical risk assessment, alongside shared decision making, should inform how the patient's care is managed as safely as possible in direct clinical settings. The way in which patients identified as having suspected or confirmed respiratory infection are managed, will vary depending on the healthcare facility estate and type of service. For more information on this, please see the NIPCM addenda including advised questions for use. In addition, each health board, health and care social partnership (HSCP), acute service or independent contractor will determine whether additional mitigation measures such as laboratory testing or self-isolation prior to elective treatment is required. The most appropriate model of care and clinical pathway will relate to local circumstances, population, setting (e.g. primary or secondary care) and pattern of delivery of care.

For IPC purposes, all patients requiring face-to-face meetings / management should be assigned the appropriate pathway determined by the screening questions as outlined in the NIPCM addenda.

Current public messaging directs people who are unwell and worried about COVID-19 to consult NHS Inform and to phone 111 as the first point of contact since most COVID-19 cases can be managed with advice from such services. NHS Inform also hosts a range of public information resources including leaflets and posters which can be printed and shared, which can be found under communication toolkit.

Appropriate safety-netting advice should be offered. NHS Inform advises patients to phone NHS 24 (call 111) if their symptoms deteriorate. In some Board areas, patients are encouraged to use their own general practice as a first point of contact, and recent Chief Medical Officer (CMO) guidance advises children under the age of 12 with respiratory

* In this guidance PHS uses the term "screening" of patients when describing the process of risk assessing patients for COVID-19 symptoms and exposure, using key questions. ARHAI use the term "triage" for this process, and this term is used in the NIPCM addenda and when citing content in these addenda.
symptoms should also use this route. In principle attendance at the healthcare setting for those suspected of COVID-19 infection should be minimised unless clinically indicated; varying service models can be used (e.g. COVID-19 pathways in wards, COVID-19 assessment centres (CACs), designated rooms in practices). If it is an emergency and an ambulance is required, when dialling 999, informing the ambulance call handler of the concerns about COVID-19 infection is essential. Scottish Ambulance Service (SAS) will triage healthcare professional (HCP) calls to provide the appropriate response.

People with suspected COVID-19, as well as those who are isolating as confirmed cases or contacts, should contact services to postpone routine appointments until after their infectious period of 10 days, unless in discussion with the service it is considered to be clinically urgent.

4.6.2 Essential transport of possible, probable and confirmed cases and contacts to home or for healthcare

The overall aim is that exposure to a potentially infectious patient to staff and/or other patients is minimised during essential transport home or to healthcare settings.

The following principles should be followed:

- Use of public transport is not recommended.

- Patients can be transported in a private vehicle by an accompanying friend or family member if they have already had significant exposure to the patient and/or are aware of the possible COVID-19 diagnosis. The patient should sit in the rear of the car and wear a face covering or surgical face mask, if available. The car should be well ventilated with open windows. All occupants of the car should ensure good hand and respiratory hygiene.

- If private transport is not available/possible, alternative arrangements should be made locally. Private commercial vehicles can be used if appropriately planned and risk assessed. Risk assessment and travel arrangements may need to be undertaken on a case by case basis. Healthcare services should consider what local arrangements need to be put in place, supplementary to SAS and other hospital
patient transport provision, to support patients to access essential healthcare whilst self-isolating.

- Travel should be undertaken as safely as possible, e.g. do not drive if too unwell to do so.
- Patients should be given clear instructions on what to do and where to go when they get to the healthcare setting to minimise risk of exposure to staff, other patients and visitors.

4.7 Reporting to local health protection teams - approach to outbreak management

Management and HPT follow-up in the different healthcare settings is outlined in COVID-19 Guidance for Health Protection Teams. The contact details for local health protection teams are available here.

A COVID-19 outbreak is normally defined as two linked cases of a disease within a specific setting over a period of 14 days. If a cluster of COVID-19 cases has no known link or has not yet been investigated for this within a setting, this should be discussed with local Infection Prevention and Control Teams (IPCT) or HPTs (as agreed locally), who may declare an outbreak following risk assessment. Individual suspected cases in the community do not need to be reported to local HPTs. However, a single case of infection in a care home, hospice or primary healthcare setting should prompt contact with the local HPT. Similarly, hospital cases should be made known to local IPCTs.

Decisions around closure of healthcare premises should be made with support of the local HPT or IPCT on the basis of a risk assessment, often as part of an Incident Management Team discussion. Clinical and social care services should not necessarily be closed to admissions on the basis of one confirmed case of COVID-19.

Guidance for the management of incidents and outbreaks in residential care home settings is available in the COVID-19 - Information and Guidance for care home settings.
Advice for the management of incidents and outbreaks in other social, community and residential settings is available in COVID-19 - Information and Guidance for social, community and residential care settings.

Guidance for the management of an outbreak in an acute setting can be found in the NIPCM according to local arrangements.

4.8 Caring for someone who has died

The IPC measures described in this document and the NIPCM continue to apply whilst the person who has died remains in the care environment including their own home. This is due to the ongoing risk of infectious transmission via contact, although the risk is usually lower than for living people. Advice in the NIPCM addendum should be followed where the deceased was known or suspected to have been infected with COVID-19.

The Scottish Government have issued further information on funerals and burial and cremation.

4.8.1 Certification of death during the COVID-19 pandemic

Details on death certification during the COVID-19 pandemic are outlined in the CMO letter dated 20 May 2020 Updated Guidance to Medical Practitioners for Death Certification during the COVID-19 Pandemic.

5. Guidance for specific healthcare settings

The core principles in section 4.1 apply across all healthcare settings. Additional information for specific settings is included in this section.
5.1 Primary care

5.1.1 Principles

Appropriate guidance on vaccination and on IPC requirements as per the NIPCM addendum should be followed in all clinical areas (e.g. general medical and dental practices, pharmacies, optometry services, physiotherapy etc). Vaccination of all staff is strongly recommended, including for those who are pregnant.

General IPC principles should also apply in "staff only" areas including maintenance of clutter free work spaces with appropriate cleaning regimes in place, physical distancing and use of FRSMs. Portable cooling fans should not be used during outbreaks of infection or where known or suspected infectious patients are being managed, but can be used in non-clinical areas, where they should be visibly clean and maintained.

5.1.2 Links to external sources

Primary care sectors will have operationalisation of COVID-19 general guidance from their own organisations. Professional bodies for many contractors (e.g. general medical and dental practice, community pharmacy, community optometry) have also operationalised IPC guidance and are expected to review this regularly. Where sector or occupation specific guidance is developed to operationalise the measures then this should be led by the key national organisation and be in line with existing health protection and IPC guidance from PHS and ARHAI/NSS respectively.

Resources in this section have been suggested by external stakeholders and may refer to Public Health England guidance. Scottish IPC guidance should always be used in Scottish services, please see the NIPCM addenda.

General dental practice and Public Dental Service:

- Scottish Dental COVID-19 Summary Page gives information on COVID-19 including the NHS Scotland Standard Operating Procedures for Dental Teams. There is also a COVID-19 Infection Prevention and Control Dental Appendix, which has been approved by the four UK Chief Dental Officers for the purposes of dentistry in Scotland and there is a plan for it to be reviewed in autumn 2021. Dental
settings are now also included in the **Scottish COVID-19 Community Health and Care Settings IPC Addendum** applying a Scottish context to the UK dental appendix. A rapid review of the mitigation of AGPs in dentistry, developed by Cochrane Oral Health and SDCEP (Scottish Dental Clinical Effectiveness Programme) is available [here](#).

Community pharmacy:

- **Community Pharmacy Scotland COVID-19 Hub**

Community optometry:

- **Eyes.Scot**: for professionals and the public - a national website for eye care services and eye health information.

General medical practice:

- **NHS Scotland: General Practice - Recovery**

### 5.2 Hospices

Hospices aim to bring dignity, care and compassion to people and their families to support end of life care. Hospices should continue to risk assess locally to allow the ongoing provision of services whilst protecting patients, visitors and staff in the context of COVID-19. Hospices are likely to have very high proportions of patients who are clinically vulnerable or at extremely high risk of severe illness. The measures taken will need to be tailored to the specific hospice setting, particularly where additional services such as home visits and day services are provided.

#### 5.2.1 Admissions

The clinical needs of patients being admitted to hospices must be accounted for, and balanced with the need for appropriate COVID-19 measures and IPC for the protection of all patients and staff.

All admissions to the hospice and transfers from other care settings should be assessed for risk of COVID-19 using the triage tool accessed [here](#). This allows hospices to support
the newly admitted patient through the appropriate COVID-19 pathway as described in the **NIPCM addendum**. Any other known or suspected infections and the need for any AGPs must be considered before patient placement within each of the pathways.

If a patient admitted to the hospice has tested positive for COVID-19 or meets the **case definition** for COVID-19 or is self-isolating for any reason, conduct a risk assessment and consider whether the admission can be delayed until the person has completed their self-isolation period. It is accepted however that some people will need to be admitted on clinical necessity or due to other circumstances whilst still within the self-isolation period in which case necessary mitigations in line with the high-risk pathway should be put in place.

All patients should have a COVID-19 PCR test undertaken on admission (unless they have tested positive within the last 90 days). If the patient is asymptomatic and all triage questions have been answered 'no' there is no need for patients to isolate until the results of this first test are received. This is consistent with guidance for acute settings in NIPCM acute addendum. Where the person is being transferred from a hospital or another care setting, a PCR test should ideally be undertaken 48 hours prior to transfer. If this is not possible, the admission should not be delayed and the person should be tested on admission to the hospice (if appropriate). The patient should be retested on day 5 if the admission test was negative to further inform a risk assessment. A new test should be performed at any point in the inpatient stay as soon as new onset of COVID-19 symptoms are recognised or there is a clinical indication to do so. If a PCR test cannot be undertaken then a risk assessment should take place to determine if it is necessary or appropriate for a person to be isolated for 10 days.

Regular testing of SARS-COV-2 for hospice staff can follow local guidance for healthcare services. LFD health board testing leads should be contacted for access to twice weekly LFDs for hospices.

### 5.2.2 Day/Overnight pass

Patients who are able to go out during the day, for example to attend a hospital appointment or simply to socialise or go shopping, should have triage questions undertaken on arrival back to the facility as per the **NIPCM addendum**. The guidance outlined on **NHS inform** on physical distancing, hand and respiratory hygiene and when to
self-isolate must be followed by patients visiting in the community, who need to be aware that the risk of community viral exposure still exists but can be mitigated with such measures. On return to the hospice, patients should be risk assessed to determine whether any potential COVID-19 risk exposure has occurred, if their COVID-19 risk level has changed and which COVID-19 pathway they should be placed on.

5.2.3 Visiting

Hospices should also apply local policies and risk assessments for visiting. PPE information for visitors can be found in the NIPCM addendum.

Information on international travel and end of life circumstances can be found in the Scottish Government Coronavirus (COVID-19): hospital visiting guidance. The hospice must carry out a risk assessment to determine if an end-of-life visit is permissible under the travel regulations and can take place with reasonable mitigations in place.

5.3 Scottish Ambulance Service

Due to the operational environment, SAS follow the UK Health Security Agency (UKHSA) COVID-19: guidance for ambulance services, which is aligned to the NIPCM.

Early contact and sharing of COVID-19 status are key when planning inter-hospital transfers or admissions, to ensure timely response and allocation of the most appropriate resources.

5.4 Secondary Care

5.4.1 Principles

Appropriate guidance and IPC requirements should be followed in clinical and non-clinical areas as per section 4.1 Core public health measures for all healthcare settings and the NIPCM addendum.
5.4.2 Management of patients in secondary care

Clinicians must assess people on arrival at the secondary care facility using the screening process and triage questions contained within the NIPCM addendum. This may be done either in the days before an elective admission with a combination of mitigations including pre-admission PCR testing, a degree of self-isolation, physical distancing and symptom vigilance or during an unplanned admission with testing and risk assessment on admission. This will determine which COVID-19 pathway the patient should be placed on and will also include details of the necessary PPE and IPC precautions that staff, patients and visitors must follow.

For all admissions, the screening questions should be completed immediately on arrival to hospital where it is safe to do so without delaying any necessary immediate lifesaving interventions.

5.4.3 Discharging patients

Guidance on the appropriate discontinuation of IPC precautions for patients recovering or recovered from COVID-19 and either remaining in hospital, being discharged to their own home or to residential care can be found in the NIPCM addendum and the COVID-19 - information and guidance for care home settings. Decisions about any clinical follow-up will be on a case by case basis.

6. Further information

Further information for health professionals can be found in the following places:

- PHS COVID-19 health protection guidance
- The Scottish Government clinical guidance
- Scottish Intercollegiate Guidance Network (SIGN)

Information for the general public can be found on NHS inform.
Pre-travel guidance can be found on fitfortravel for the public, and on TRAVAX for health professionals.
7. Appendices

Appendix 1 – Self-isolation periods for cases and contacts in different settings

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

<table>
<thead>
<tr>
<th>Case or Contact</th>
<th>Staff or Residents</th>
<th>Self-isolation period (days) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 cases</td>
<td>Residents</td>
<td>14</td>
</tr>
<tr>
<td>COVID-19 cases</td>
<td>Staff</td>
<td>10</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>Residents</td>
<td>14</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>Staff**</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 1b: Self-isolation periods for cases and contacts - healthcare settings

<table>
<thead>
<tr>
<th>Case or Contact</th>
<th>Staff or Residents</th>
<th>Self-isolation period (days) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 cases</td>
<td>In-patients (case) remaining in the hospital</td>
<td>14</td>
</tr>
<tr>
<td>COVID-19 cases</td>
<td>Patient (case) discharged/transferred to any residential/care home/hospice setting</td>
<td>14</td>
</tr>
<tr>
<td>COVID-19 cases</td>
<td>In-patients (case) discharged to own home</td>
<td>14</td>
</tr>
<tr>
<td>COVID-19 cases</td>
<td>Staff</td>
<td>10</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>In-patients (contact) remaining in the hospital</td>
<td>14</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>Patient (contact) discharged/transferred to older adult residential setting/care home</td>
<td>14</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>In-patients (contact) discharged to residential setting other than older adult</td>
<td>Requires risk assessment with regards to 10 or 14 days</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>In-patients (contact) discharged to own home</td>
<td>10</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>Staff**</td>
<td>10</td>
</tr>
</tbody>
</table>
Table 1c: Self-isolation periods for cases and contacts - prisons/custody settings

<table>
<thead>
<tr>
<th>Case or Contact</th>
<th>Staff or Residents</th>
<th>Self-isolation period (days) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 cases</td>
<td>People in prisons/custody settings</td>
<td>10</td>
</tr>
<tr>
<td>COVID-19 cases</td>
<td>Staff in prisons/custody settings</td>
<td>10</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>People in prisons/custody settings</td>
<td>10</td>
</tr>
<tr>
<td>Contacts of cases</td>
<td>Staff in prisons/custody settings***</td>
<td>10</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Case or Contact</th>
<th>Self-isolation period (days) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 cases</td>
<td>10</td>
</tr>
<tr>
<td>Contacts of cases- adults</td>
<td>10*** (default period unless exemption conditions apply)</td>
</tr>
<tr>
<td>Contacts of cases- 5-18 years and 4 months</td>
<td>10*** (default period unless exemption conditions apply)</td>
</tr>
<tr>
<td>Contacts of cases &lt; 5 years</td>
<td>Exempt from self-isolation (unless symptoms develop)</td>
</tr>
<tr>
<td>Contacts (fully vaccinated) of cases (any age) who have had a positive PCR test in the previous 90 days</td>
<td>Exempt from self-isolation (unless symptoms develop); NB adults must also be doubly vaccinated</td>
</tr>
</tbody>
</table>
### Table 1e: Self-isolation periods for cases and contacts - returning travellers

<table>
<thead>
<tr>
<th>Case or Contact</th>
<th>Self-isolation period (days) *</th>
</tr>
</thead>
</table>
| Traveller arriving in Scotland via air travel from outside the common travel area * | For managed quarantine: 10 days self-isolation counting day 1 as the first full day after the traveller arrives in Scotland. Day 0 is considered day of arrival to Scotland.  
For home isolation (non-red-listed countries): 10 days self-isolation counting Day 1 as the first full day after the traveller departed from or transited through an non-exempt country. Day 0 is considered day of departure from or transited through the non-exempt country*.  
Fully vaccinated travellers (according to accepted UK vaccines) are exempt from 10-day self-isolation.  
No self-isolation required for travellers from green-listed countries. |

### Additional points to note

- 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.
- For contacts, day 1 of isolation is the last day exposure occurred (with a case) or the case's day 1.
- Isolation ends at 23h59 on the 10th or 14th day of isolation (as appropriate) *; travel regulations manage days differently.
- For travellers who are required to enter isolation for quarantine purposes:
o Where isolation for travellers returning from red-list countries is in a managed quarantine facility (MQF) then day 1 is established in Scottish regulations and relates to the day after arrival in Scotland, where the traveller has travelled in or through a non-exempt country in the previous 10 days.

o Where isolation is at home then day 1 is established in Scottish regulations and relates to the day after departure from a non-exempt country.

o In both cases, regulations require that for any positive test result, the traveller should remain in quarantine until the end of the 10th day after the test was taken.

o If the traveller’s day 2 test result is positive there is no requirement to submit a second test on day 8.

*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 contact develops symptoms or has a positive COVID-19 test result

- A case who tested positive whilst asymptomatic who then develops symptoms within the isolation period

- A returned traveller develops symptoms during the quarantine period

- A returned traveller has been identified as a flight contact

- Considerations made by an incident management team (IMT) 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, fully vaccinated, COVID-19 testing negative, further daily LFD testing) – see section 4.5.1. 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 for details.

Further information can also be found in COVID-19: international travel and managed isolation (quarantine) guidance.
Appendix 2 – Contact details for local Health Protection Teams

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


