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| V1.1    | 28/04/2020 | Testing and admission information updated  
Providing care for residents during pandemic section updated                                                                                              |
| V1.2    | 01/05/2020 | Testing information updated                                                                                                                                                                                          |
| V1.3    | 20/05/2020 | Case definition updated                                                                                                                                                                                            |
| V1.4    | 21/05/2020 (not published) | 1 Measures to prevent spread of COVID-19 and protect people at increased risk of severe illness: information on risk assessment added  
3 Providing care for residents: outbreak information updated  
6 Admission of individuals to care home: updated  
7 Testing in care home: updated  
9 PPE: AGP list updated  
16 Caring for someone who has died: Updated external link  
16 Personal or work travel and physical (social) distancing: re-added  
17 Visiting care homes: updated  
Annex 1: re-added                                                                 |
| V1.5    | 30/05/2020 (not published) | Included asymptomatic positive individuals where symptomatic individuals mentioned throughout  
Test and protect advice added throughout document and summarised in section 1  
3 Providing care for residents during COVID-19 pandemic: declaring outbreak over and reopening facility for admissions advice added.  
6. Added section on what to do when testing is not possible  
9.1 PPE: fit testing advice added  
11. Environmental decontamination to take place at least twice daily  
15.3 Added importance for staff and their households to self-isolate whether symptomatic or asymptomatic PCR positive  
15.4 Added link to interim guidance on PCR testing in care homes and management of test positive residents and staff  
18 Death certification during COVID-19 pandemic: section added  
Annex 1: Household isolation and test and protect sections added                                                                 |
| V1.51   | 08/06/2020 (not published) | 3 Providing care for residents during COVID-19 pandemic: outbreak advice updated  
6 Admission of individuals to the care facility: non-COVID admissions from hospitals advice updated                                                                 |
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Changed all mention of physical (social) distancing to physical distancing throughout  
16 Personal or work travel and physical distancing: addition of Transport Scotland face coverings information                                                                 |
| V1.6    | 31/07/2020 | 1 Measures to prevent spread of COVID-19 and protect people at increased risk of severe illness: shielding advice updated  
16 Personal or work travel and physical distancing: updated with Phase 3 information.  
Annex 1: shielding advice updated                                                                 |
| V1.7    | 17/09/2020 | 1 Measures to prevent spread of COVID-19 and protect people at increased risk of severe illness: advice updated  
1.2 Spread of COVID-19 in care homes: information updated                                                                 |
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Scope of the guidance

This guidance is to support those working in care home settings to give advice to their staff 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.

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

Health Protection Scotland (HPS) (now part of Public Health Scotland) will update this guidance as needed and as additional information becomes available.
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. Symptoms range from mild to moderate illness to pneumonia or severe acute respiratory infection requiring hospital care. Death is an important outcome, especially in older age groups. COVID-19 was declared a pandemic by the World Health Organisation on 12 March 2020.

The first cases in the UK were detected on 31 January 2020, and on 23 March 2020 the UK entered “lockdown”.

A range of public health measures have been used to control transmission of SARS-CoV-2, including public awareness of symptoms, physical distancing, shielding advice, and infection, prevention and control measures. As part of the gradual relaxation of lockdown measures the Test and Protect programme, which includes contact tracing, is being implemented to facilitate a sustained reduction in new cases, outbreaks and to reduce transmission.

This guidance is relevant to all services registered with the Care Inspectorate as care homes, except those for children and young people. Other residential care services should use 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 HPT.

1. Measures to prevent spread of COVID-19 and protect people at increased risk of severe illness.

There is currently no vaccine to prevent COVID-19. The following measures are recommended to help reduce the spread of COVID-19 and to protect people at increased risk of severe illness:

Physical distancing measures should be followed by everyone in line with the Scottish Government advice to stay safe (physical distancing). Guidelines vary by age group – for up to date information see the Scottish Government website. The aim of physical distancing measures is to reduce the transmission of COVID-19.

People who are at increased risk of severe illness from coronavirus should strictly follow physical distancing measures (this includes those with certain medical conditions, pregnant or aged 70 or older). Up to date information can be found on the NHS Inform website. This also includes additional detail on how to adapt physical distancing for those with additional needs.

Shielding is a measure to protect people, including children, who are at extremely high risk severe illness from COVID-19 because of certain underlying health conditions. It involves strict adherence to physical distancing, even in the home restriction of social interactions. See NHS Inform website for further information. This has recently been relaxed.
Scottish Government advise:

“People who have been advised to shield because of COVID-19, will no longer have to do so from 1 August and will be asked to follow general safety guidance, as well as follow stringent physical distancing and hygiene measures”.

However, relaxation of shielding arrangements differs for individuals living in care homes where specific guidance for that setting should continue to be followed: COVID-19: adult care homes visiting guidance.

Stay at home guidance for households with possible COVID-19 should be followed by people with symptoms or a COVID-19 diagnosis and their household contacts to reduce the community spread of COVID-19. ‘Stay at home’ advice can be found on NHS Inform.

Test and protect is a public health measure designed to break chains of transmission of COVID-19 in the community. 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, so that if they have the infection they are less likely to transmit to it to others. Further details can be found on the Scottish Government website and NHS Inform.

Physical distancing by staff of 2 metres should be followed in all areas of the workplace, including non-clinical areas. Where 2 metre physical distancing cannot be maintained, for example when providing direct care, the use of PPE in accordance with guidance will reduce the risk of exposure. A local review of existing practice may need to be considered to introduce measures, such as staggering staff breaks, to limit the density of staff in specific areas. Other measures such as use of Perspex (or similar) screens may be considered to reduce risk in non-clinical encounters.

Staff (such as health and care workers) with underlying health conditions that identify them at increased risk of severe illness from COVID-19, including those who are immunosuppressed, should not provide direct care to residents with possible or confirmed COVID-19. A risk assessment should be undertaken as it may not be appropriate for them to work in the care home at all. Staff who think they may be at increased risk, including pregnant staff, should seek advice from their line manager or local Occupational Health service. Further information can be found in Guidance for NHS Scotland workforce Staff and Managers on Coronavirus.

Face coverings: The Scottish Government announced that people aged 5 years and over must wear a face covering on public transport, in public transport premises (e.g. train stations and airports) and shops. There are some exemptions to this requirement; further information can be found on the Scottish Government website. Members of the public visiting care homes for the elderly or adult hospitals (including to attend an appointment) are also asked to
wear a face covering where it is not always possible to maintain a 2 metre distance from other people. Further information is available here.

1.1 Symptoms of COVID-19 for residents in care homes

The most common symptoms of COVID-19 are:

- New continuous cough
  
or
- Fever
  
or
- Loss of/ change in sense of smell or taste.

Older or immune-compromised residents may present with atypical or non-specific symptoms. See Scottish Government’s COVID-19: clinical guidance for nursing home and residential care residents for more details on clinical presentation.

1.2 Spread of COVID-19 in care homes

COVID-19 is spread through respiratory droplets produced when an infected person coughs or sneezes. The evidence to date continues to point towards transmission mainly occurring via contact from symptomatic cases. This can occur through respiratory droplets, by direct contact with infected persons, or by indirect contact via contaminated objects and surfaces. Shedding of SARS-CoV-2 is highest early in the course of the disease, particularly within the first 3 days from onset of symptoms. However, there is also some evidence that transmission to others may be possible 1-3 days prior to symptom onset (pre-symptomatic phase) or in individuals that develop infection but don’t develop symptoms (asymptomatic phase); however the evidence for this is still emerging and is limited. The risk of transmission is highest when there is close contact with an infected person who is symptomatic and this risk increases the longer the contact lasts.

There are two routes by which COVID-19 can be spread:

- **Directly**: from close contact with an infected person (within 2 metres) where respiratory secretions can enter the eyes, mouth, nose or airways. This risk increases the longer someone has close contact with an infected person.

- **Indirectly**: by touching a surface, object or the hand of an infected person that has been contaminated with respiratory secretions and then touching own mouth, nose or eyes.

Further HPS guidance for other settings, including Social, Community and Residential Care and Domiciliary Care, is available on the HPS website.
2. Preventing spread of infection in care homes

The National Infection Prevention and Control Manual (NIPCM) provides information and evidence on Standard Infection Control Precautions and Transmission Based precautions which should be applied for COVID-19 disease.

Hand hygiene

Hand hygiene is essential to reduce the transmission of infection in health and care settings. All staff, residents and visitors should clean their hands with soap and water or, where this is unavailable, alcohol-based hand rub (ABHR) when entering and leaving areas where care is being delivered. See Appendix 2 for best practice on hand hygiene.

Hand hygiene must be performed immediately before every episode of direct care and after any activity or contact that potentially results in hands becoming contaminated, including the removal of personal protective equipment (PPE), equipment decontamination and waste handling.

Before performing hand hygiene:
- expose forearms (bare below the elbows)
- remove all hand and wrist jewellery (a single, plain metal finger ring is permitted but should be removed (or moved up) during hand hygiene)
- ensure finger nails are clean, short and that artificial nails or nail products are not worn
- cover all cuts or abrasions with a waterproof dressing

If wearing an apron rather than a gown (bare below the elbows), and it is known or possible that forearms have been exposed to respiratory secretions (for example cough droplets) or other body fluids, hand washing should be extended to include both forearms. Wash the forearms first and then wash the hands.

Staff should support any residents with hand hygiene regularly where required.

Respiratory and cough hygiene – ‘Catch it, bin it, kill it’

Residents, staff and visitors should be encouraged to minimise potential COVID-19 transmission through good respiratory hygiene measures which are:

- disposable, single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose – used tissues should be disposed of promptly in the nearest waste bin
- tissues, waste bins (lined and foot operated) and hand hygiene facilities should be available for patients, visitors and staff
- hands should be cleaned (using soap and water if possible, otherwise using ABHR) after coughing, sneezing, using tissues or after any contact with respiratory secretions and contaminated objects
- encourage residents to keep hands away from the eyes, mouth and nose
Some residents may need assistance with containment of respiratory secretions; those who are immobile will need a container (for example a plastic bag) readily at hand for immediate disposal of tissues.

3. Providing care for residents during COVID-19 pandemic

Ensure daily monitoring of all residents for COVID-19 symptoms, or other signs of illness. Residents with cognitive impairment may be less able to report symptoms. Elderly or frail residents with co-morbidities may also present with atypical and non-specific signs of illness. Further information can be accessed here. If a resident becomes unwell contact the GP for clinical advice.

- If it is an emergency and you need to call an ambulance, dial 999 and inform the call handler or operator that the unwell person may have coronavirus (COVID-19).

A single suspected or confirmed case of infection should prompt contact with your local HPT as it may also signal the start of a possible outbreak.

A COVID-19 outbreak is defined as two 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 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. Assessment of resident cases when considering any potential outbreak should also include suspected or confirmed cases who have either been transferred from the care home to hospital or a suspected or confirmed COVID-19 individual who has died within the same time period. These criteria may apply to other residential settings if there are groups of clinically vulnerable individuals or extremely vulnerable individuals living in group settings. This will need to be considered on an individual basis.

On identification of a new suspected or confirmed COVID-19 case, the care home must immediately contact the local HPT 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 home circumstances, testing of all residents and staff may be considered necessary at this point.

Upon receipt of a positive result a HPT conducts a public health risk assessment to decide if whole home testing is appropriate. There is discretion for local HPTs to assess whether whole home testing is appropriate where, for example, a weak PCR positive turns out to be negative upon re-testing or there is a false positive result for another reason. If for whatever reason the HPT decided not to go ahead with whole home testing after one case only (e.g. a false positive test), if there was a second case then they must consider it.

An outbreak will be declared by the local HPT following identification of 2 linked cases, at least one of which has been laboratory confirmed. At this point, if whole home testing of all residents and staff has not already been carried out, it must be actively considered. A number of other measures will follow as guided by the HPT.
To declare an outbreak over, there should be no new symptomatic or confirmed COVID 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 be satisfied that existing cases have been isolated/cohorted effectively and symptoms should be resolving. 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 the Care Inspectorate.

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. A fine balance must be struck such that person-centredness must work in combination with measures to protect residents, staff and the wider population.

### 4. Measures to protect residents in the shielding category

Shielding measures have been relaxed for the general population. Care home residents who were previously shielding due to the nature of the communal setting, should adhere to the general guidance for family and friend visiting for all care home residents. Further information can be found on the Scottish Government website.

Shielded residents can participate in phased visiting as per other care home residents. To help reduce the spread of COVID-19 and to protect people at increased risk of severe illness, the following measures should still be followed:

- **Residents**
  - Should have their own single room with en-suite facilities, where possible (see section 8 otherwise)
  - Must not be placed in cohorts
- **Staff**
  - Must wear PPE when entering their room and within 2 metres of the resident

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

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

Where an individual 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. This should be discussed with the local HPT.
Residents who are identified as close contacts should be isolated individually in single rooms for 14 days after last exposure to a possible 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 undergoing shielding should not be placed in a cohort. Cohorting of residents should be discussed with the local HPT.

All identified contacts should 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. If they have been cohorted with other individuals, the other residents’ follow-up period recommences from the date of last exposure. Ensure that residents who have had no contact with COVID-19 cases are separated from residents with symptoms or a diagnosis of COVID-19.

### 6. Admission of individuals to the care home

To minimise the risk of viral introduction to a care home from residents transferring in, all resident transfers must complete a total of 14 days of isolation either starting on or including the date of transfer. PCR screening of residents for transfer purposes only provides partial reassurance. Infection may still develop subsequently at any time during the incubation period.

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

- All COVID-19 patients in hospital who are to be admitted to a care home
- All other admissions to care homes

The presumption should be that residents being admitted to a care home should have a consented PCR test before or on admission unless it is in the clinical interests of the person to be moved and a risk assessment can support this; local HPTs can advise in more complex situations. Even if a COVID-19 test result is negative, a 14 day period of isolation must be completed.

For residents without the capacity to consent to a test, see [COVID-19: clinical guidance for nursing home and residential care residents](#) for further information.

### Admission of COVID-19 recovered residents from hospital

Residents should always be isolated for a minimum of 14 days from symptom onset (or first positive test if symptoms onset undetermined) including absence of fever for 48 hours (without use of antipyretics). They do not require to spend all 14 days in hospital but should have 2 negative tests before discharge from hospital (testing can be commenced on day 8). Tests should be taken at least 24 hours apart and preferably within 48 hours of discharge. Where testing is not possible (e.g. resident doesn’t consent or it would cause distress) a risk assessment and an agreed care plan for the remaining period of isolation up to 14 days in the home must be agreed.
Further details can be found in [Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings](#).

**Admission of non-COVID-19 residents from hospital**

All 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 should be undertaken in conjunction with the care home. Testing should be done preferably within 48 hours prior to discharge from hospital. A single negative result should be available before discharge. 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 prior to the test result being available. Whether the result is positive or negative, 14 days of isolation must be completed.

Further details on testing requirements can be found in [Guidance for Sampling and Laboratory Investigations](#).

**Admissions from the community**

All other admissions from the community should have at least one test performed before or on admission and be isolated on admission for 14 days. Risk assessment prior to admission should be undertaken to ensure that appropriate isolation facilities are available, taking into account requirements for the resident’s care. Where testing is not possible (e.g. resident doesn’t consent, detrimental consequences or it would cause distress) then there must be an agreed care plan for the 14 days of isolation in the care home.

**Residents who temporarily leave the care home**

Residents who temporarily leave the care home to attend essential personal business, e.g. attending a funeral, hospital appointment in A&E, out-patients or as a day case, do not require the same measures as a new admission upon their return.

The physical distancing and face covering guidance on [NHS Inform](#) must be followed during day visits. Any concerns about potential exposure to COVID-19 during a day visit will require a local risk assessment to determine whether additional measures are needed.

**7. Testing in the care home**

All care home residents who develop symptoms suggesting possible COVID-19 infection should be tested as part of clinical assessment.

Any staff presenting with suspected COVID-19 symptoms should be sent home immediately and advised to be tested. Similarly, if they report illness from home, they are advised to be tested as soon as possible, ideally within 3 days of symptom onset. See [Staff Testing](#) section of this guidance for further information.
Where an outbreak is suspected on the basis of one confirmed case, an urgent health protection assessment is required, led by the local HPT. If an outbreak is declared, particular attention must be given to wider testing, including all residents and staff, irrespective of the presence of symptoms (subject to consent and clinical practicality).

Further to this, any care home that has staff links with another facility where an outbreak has been declared, must also be assessed for wider testing as part of the health protection response.

This is consistent with the First Minister’s announcement regarding testing of residents and staff in care homes on 1st May 2020.

“We now intend to undertake enhanced outbreak investigation in all care homes where there are any cases of COVID - this will involve testing, subject to individuals’ consent, all residents and staff, whether or not they have symptoms.

In addition, where a care home with an outbreak is part of a group or chain and staff might still be moving between homes, we will also carry out urgent testing in any linked homes.

We will also begin sampling testing in care homes where there are no cases. By definition this will also include testing residents and staff who are not symptomatic.

This is a significant expansion and we do not underestimate the logistical and workforce requirements.

Now we have the increasing testing capacity, we will make it happen as swiftly as practicable.”

Further details can be found on the Scottish Government website.

The Cabinet Secretary for Health and Sport further announced on 19th May:

“All care home staff will be offered testing, regardless of whether the care home in which they work has a Covid-19 case. That will be an iterative process, with testing undertaken every seven days.”

Therefore, as indicated in this policy, non-outbreak care homes are expected to undertake weekly COVID screening of all staff. This is normally achieved using the UK Government Social Care testing portal through the “Lighthouse” testing facility from COVID-19: testing for care home staff in Scotland, but can in certain circumstances be arranged according to local pathways.

Staff who have tested positive and recovered from the infection or returned well from 10 days of self-isolation do not require to be repeatedly tested during these weekly cycles. Staff re-testing is indicated if COVID-19 symptoms recur, but is not part of the weekly cycle of screening.
For additional information on testing in care home settings, see Guidance on COVID-19 PCR testing in care homes and the management of COVID-19 PCR test positive residents and staff.

8. Care Home Placement for symptomatic 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 symptom onset undetermined). The resident should 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.

Where en-suite facilities are not available, designate a commode that only that resident will use if possible. If a commode is used and cannot be dedicated to the resident, ensure it is cleaned as per Appendix 4. 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, ABHR should be applied afterwards.

Only essential staff should enter the resident’s room, wearing appropriate PPE as per section 9. 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 aerosols or respiratory droplets.

Isolation can be discontinued once the 14 day isolation period is complete if there has been absence of fever for 48 hours (without the use of antipyretics). Before IPC measures are stepped down, consider any additional ongoing IPC measures which may be required for loose stools or any other infectious organisms.

If a transfer to hospital is required, the ambulance service and the receiving ward/department should be informed if the resident is a suspected or confirmed COVID-19 and of the requirement for isolation on arrival.

The area must be cleaned as detailed in the environmental decontamination section 11 below before any other residents use the facilities.

Cohorting of symptomatic residents:

Cohorting in care homes should be undertaken with care. Residents who are shielding (extremely high risk of severe illness) must not be placed in cohorts and should be prioritised for single occupancy rooms. Where all single isolation room facilities are occupied and cohorting is unavoidable, then cohorting can be arranged so that

- Confirmed COVID-19 residents are placed in multi-occupancy rooms together.
- Suspected COVID-19 residents are placed in multi occupancy rooms together.
9. Personal Protective Equipment (PPE)

9.1 Personal Protective Equipment (PPE)

General PPE guidance as agreed across the UK by the 4 CMOs remains in place. Scottish Government guidance on the extended use of PPE in care homes has been issued recently (see below) and is consistent with the previous statement of 2nd June 2020 (accessible here) supported by COSLA and the SJC Unions on the use of PPE.

Table 2 was contained within the COVID-19 – Infection Prevention and Control guidance and describes PPE usage applicable to care homes when caring for suspected or confirmed cases – it is available in Appendix 6.

Sustained transmission of COVID-19 is occurring within Scotland and therefore Table 4 provides additional PPE considerations, taking into account individual risk assessment for this new and emerging pathogen – also available in Appendix 7.

Appendix 3 describes the procedures for putting on and removing PPE. All staff must be trained on how to use PPE appropriate for their role to limit the spread of COVID-19.

PPE used for sessional use

Aprons and gloves are subject to single use as per Standard Infection Control Precautions (SICPs), and must be changed between residents. Respirators, fluid-resistant (Type IIR) surgical masks (FRSM), eye protection and disposable fluid repellant coveralls or long-sleeved disposable fluid repellant gowns can be subject to sessional use in circumstances outlined in the PPE tables.

A single session refers to a period of time where health and care staff are undertaking duties in a specific setting within the care home, e.g. when providing direct care. Staff can go between residents using sessional PPE. A session ends when the health and care worker leaves the specific setting within the care home, for example the COVID-19 cohort area. Sessional PPE should not be worn moving between COVID-19 and non COVID-19 areas.

Sessional use should always be risk assessed and considered where there are high rates of cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.

Extended PPE use in Care Homes

The Scottish Government has produced COVID:19 Interim guidance on the extended use of medical masks and face coverings in hospitals and care homes. It states:

“It is now recommended that staff working in a clinical area of an acute adult (incl. mental health) or community hospital or in a care home for the elderly should wear a medical face mask at all times throughout their shift.
In relation to care homes, it is expected that this advice will be relevant in the first place to care homes for adults and older people. “Extended” in this regard means that a medical face mask will be worn throughout the shift, but the face mask can be removed and replaced as necessary (washing your hands before the mask is removed), and as recommended during the shift, including e.g. if it becomes contaminated, damaged or moist."

For further information – see here.

PPE for Aerosol-Generating Procedures (AGPs)

Table 2 also describes the additional PPE required if undertaking an Aerosol Generating Procedure (AGP) – Table 2 can found in Appendix 6. The local HPT can advise on this. AGPs should be avoided where possible.

The following procedures are considered AGPs:

- Respiratory tract suctioning
- Bronchoscopy
- Dental procedures (using high speed devices such as ultrasonic scalers and high speed drills)
- High Flow Nasal Oxygen (HFNO)
- High Frequency Oscillatory Ventilation (HFOV)
- High speed cutting in surgery/post mortem procedures if this involves the respiratory tract or paranasal sinuses
- Induction of sputum using nebulised saline
- Manual ventilation
- Non-invasive ventilation (NIV): Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- Tracheal intubation and extubation
- Tracheotomy or tracheostomy procedures (insertion or removal)
- Upper ENT airway procedures that involve suctioning
- Upper gastro-intestinal endoscopy where there is open suctioning of the upper respiratory tract

*Chest compressions and defibrillation (as part of resuscitation) are not considered AGPs; first responders can commence chest compressions and defibrillation without the need for AGP PPE while awaiting the arrival of other personnel who will undertake airway manoeuvres. On arrival of the team, the first responders should leave the scene before any airway procedures are carried out and only return if needed and if wearing AGP PPE.

Certain other procedures/equipment may generate an aerosol from material other than an individual’s secretions but are not considered to represent a significant infection risk and do not require AGP PPE. Procedures in this category include:
• administration of humidified oxygen;
• administration of medication via nebulisation.

Note: During nebulisation, the aerosol derives from a non-patient source (the fluid in the nebuliser chamber) and does not carry patient-derived viral particles. If a particle in the aerosol coalesces with a contaminated mucous membrane, it will cease to be airborne and therefore will not be part of an aerosol.

For residents with suspected/confirmed COVID-19, any of the potentially infectious AGPs listed above should only be carried out when essential. The required PPE for AGPs should be worn by those undertaking the procedure and those in the room, as detailed above. Where possible, these procedures should be carried out in a single room with the doors shut. Only those staff who are needed to undertake the procedure should be present.

It is the responsibility of care home providers to ensure that all staff have been fit tested for FFP3 respirators, when appropriate. If you do not anticipate the need for FFP respirators and are not caring for anyone currently receiving AGPs such as CPAP, these should not be ordered or stockpiled and any surplus stock should be returned.

9.2 Access to personal protective equipment (PPE)

All services that are registered with the Care Inspectorate that provide health and care support and have an urgent need for PPE after having fully explored local supply routes/discussions with NHS Board colleagues, can contact a triage centre run by NHS National Services for Scotland (NHS NSS).

Please note that in the first instance, this helpline is to be used only in cases where there is an urgent supply shortage after “business as usual” routes have been exhausted.

The following contact details will direct providers to the NHS NSS triage centre for social care PPE: Email: support@socialcare-nhs.info Phone: 0300 303 3020. The helpline will be open (8am - 8pm) 7 days a week.

10. Care Equipment

Where possible use single-use equipment and dispose of after use.

Where single use is not possible, use dedicated care equipment in the resident’s room; do not share this equipment with other residents. If it is not possible to dedicate pieces of equipment to the resident, such as commodes or moving aides, these must be decontaminated immediately after use and before use of any other resident following the guidance in Appendix 4.

Do not use fans that re-circulate the air and open windows for ventilation if it is safe to do so.

Try to keep the room clutter-free and avoid storing any unnecessary equipment or soft furnishings in residents own rooms to prevent unnecessary contamination of items.
11. Environmental decontamination (cleaning and disinfection)

Staff carrying out the cleaning must be familiar with the required environmental and equipment decontamination processes, be trained in these accordingly and ensure they are wearing appropriate PPE. Staff responsible for cleaning should be advised to clean the COVID-19 areas and isolation room(s), bathroom/shower and toilet facilities after all other unaffected areas of the care home have been cleaned.

COVID-19 affected areas should be cleaned at least twice daily paying particular attention to common touch surfaces such as door handles, tables, tablets, mobile phones, light switches, remote controls and bed rails.

Coronaviruses are readily inactivated by commonly available disinfectants such as alcohol (70% ethanol) and chlorine-releasing agents (sodium hypochlorite at 1,000 ppm av. cl.). Therefore, decontamination of the environment should be performed as per Appendix 5 using either

- A combined detergent disinfectant solution at a dilution of 1000 parts per million available chlorine (ppm available chlorine (av.cl.));

or

- A detergent clean followed by disinfection (1000 ppm av.cl.).

In the event of a blood or body fluid spillage, keep people away from the area. Use a spill-kit if available, using the PPE within the kit or PPE provided by the employer/organisation and follow the instructions provided with the spill-kit.

Environmental decontamination where the suspected or confirmed case no longer requires the room/ environment

The immediate area occupied by the resident and any equipment used, should be cleaned using the methods in Appendix 5. Additionally, this includes removal and laundering of all curtains and bed linen and screens if in place. Once this process has been completed, the area can be put back into use.

Any public areas where a symptomatic or a COVID-19 diagnosed individual has only passed through (spent minimal time in, e.g. corridors), and which are not visibly contaminated with any body fluids, do not need to be further decontaminated beyond routine cleaning processes.

Decontamination of soft furnishings may require to be discussed with the local HPT. If the soft furnishing is heavily contaminated, you may have to discard it. If it is safe to clean with standard detergent and disinfectant alone then follow appropriate procedure.

In situations where belongings of a deceased resident are being removed, the belongings should first be cleaned with a general household detergent active against viruses and bacteria.
12. Waste

If the care home has a clinical waste contract, all waste belonging to the affected resident can be placed in the clinical waste and disposed of immediately. There is no need to hold waste for 72 hours where a clinical waste stream is available.

If the care home does not have a clinical waste contract, ensure all waste items that have been in contact with the resident (e.g. used tissues and disposable cleaning cloths) are disposed of securely within disposable bags. When full, the plastic bag should then be placed in a second bin bag and tied. These bags should be stored in a secure location for 72 hours before being put out for collection.

13. Safe Management of Linen

Any towels or other laundry used by the resident diagnosed with COVID-19 should be treated as infectious and placed in a bag before removing from the isolation room and placing directly into the laundry hamper/bag. Take the laundry hamper as close to the point of use as possible, do not take inside the isolation room. When handling linen do not:

- Rinse, shake or sort linen on removal from beds
- Place used/infectious linen on the floor or any other surface e.g. table top
- Re-handle used/infectious linen when bagged
- Overfill laundry receptacles; or
- Place inappropriate items in the laundry receptacle.

14. Staff Uniforms

If available, laundry services should be used to launder staff uniforms. If this is not available uniforms should be transported home in a disposable plastic bag. 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.

15. Staffing

15.1. Staff Cohorting (working in dedicated teams)

Assigning a dedicated team of staff to care for residents with COVID-19 is an additional IPC measure which can help prevent onward spread of infection. This should be implemented whenever there are sufficient levels of staff available (so as not to have a negative impact on non-affected resident care).
15.2. Minimise external staff

- Clinical staff must be able to attend for essential clinical assessments and treatment of residents, though methods such as telephone and telemedicine should increasingly be used wherever feasible. They do not require COVID-19 screening; any queries should be directed to the local HPT.
- The use of bank or agency staff should be minimised. Where used, they should only work for one care home.
- Contractors on site should be kept to a minimum and only essential work carried out.

15.3. 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 including for:

- Self-isolation if they or their household members develop symptoms or are diagnosed with COVID-19 – see NHS Inform.
- Test and Protect - see NHS Inform.
- **Physical distancing** guidance where safe to do, e.g. during break times and in office space
- Infection prevention and control (ensure there is also sufficient work and training time and supplies to facilitate good infection control, including PPE use).
- Scottish Government [COVID-19: social care staff support fund guidance](https://www.gov.scot/publications/covid-19-social-care-staff-support-fund/) 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.

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:

- staff self-isolating as a case or as a contact;
- time required for weekly staff screening
- additional time required for IPC measures and training

Ensure there is adequate access to/supplies:

- PPE
- Access to IPC guidance/ training materials

15.4. Staff who have contact with a case of COVID-19 at work

Staff who come into contact with a COVID-19 resident or any individual suspected of having COVID-19 while not following appropriate infection prevention and control measures, e.g. practising good hand hygiene, wearing personal protective equipment (PPE) should follow
the advice in the management of exposed staff and patients in health and social care settings guidance.

All staff should be vigilant for COVID-19 symptoms during the incubation period following exposure (up to 14 days). If staff develop symptoms they should stay at home and seek advice from NHS Inform or occupational health department as per the local policy for symptomatic testing.

15.5. 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 should be discussed with the local HPT when reporting suspected cases to them. It is usually possible to prioritise appointments for key workers and their household members. Further information is available on NHS Inform.

Weekly care home staff screening for COVID-19 is in place – see Guidance on COVID-19 PCR testing in care homes and the management of COVID-19 PCR test positive residents and staff. Arrangements for this can be made directly by the care home manager via the UK Government Testing ‘Lighthouse’ service with further information available from COVID-19: testing for care home staff in Scotland.

Visiting staff do not require testing before attending a care home: in particular Care Inspectorate inspection teams, Health Protection Teams, Environmental Health Officers and others with statutory roles as well as members of the Primary Care team. Symptom vigilance, hand hygiene, respiratory hygiene, appropriate PPE and physical distancing are the key and essential elements of good infection control and must be adhered to as advised by the Care Home by all visitors.

15.6. Staff who have recovered from COVID-19

Staff can return to work:
- after at least 10 days from symptom onset, provided clinical improvement has occurred and they have been apyrexial, without the use of antipyretics for 48 hours
- if the only persistent symptoms after 10 days is a cough (post-viral cough known to persist for several weeks in some cases) and/or a loss of or a change in sense of smell (anosmia) or taste.

Asymptomatic staff who have been excluded from work on the basis of a positive PCR test during weekly screening, and remain asymptomatic after 10 days can return to work.

PCR re-testing or clearance testing is not required.

See the guidance on COVID-19 PCR testing in care homes and the management of COVID-19 PCR test positive residents and staff for further information.
Initial PCR positive result in an asymptomatic staff member as a result of weekly screening will need correlation with labs and any clinical considerations as part of the HPT’s assessment since a 28 day visiting pause may not be required: COVID-19: adult care homes visiting guidance.

Staff who have had confirmed COVID-19 and have since recovered must continue to follow the IPC measures as for all other staff including PPE, but do not require routine weekly screening unless they become symptomatic.

16. Personal or work travel and physical distancing

**Physical distancing** and **staying safe** advice is in place for all.

When using public transport (buses/trams/subways/trains) and private/commercial vehicles, aim to maintain a 2 metre physical distance whenever possible. Where people from different households are sharing a private vehicle (car, taxi, minibus, lorries) then consideration should be given to how physical distancing can be applied within the vehicle, where possible. Where this is not possible and you are travelling with non-household members, limit the number of passengers and space out as much as possible. People who are in the higher risk category should consider carefully how they can apply physical distancing advice stringently.

The Scottish Government have the following advice for **Phase 3**:

“In enclosed spaces, where physical distancing is more difficult and where there is a risk of close contact with multiple people who are not members of your household, you should wear a **face covering**.

People must wear a **face covering** in shops and on public transport and public transport premises such as railway and bus stations and airports. This applies to open-air railway platforms, but not to bus stops.

There is no evidence to suggest there might be a benefit outdoors from wearing a face covering unless in a crowded situation.

Physical distancing, hand hygiene and respiratory hygiene are the most important and effective things we can all do to prevent the spread of coronavirus. The wearing of face coverings must not be used as an alternative to any of these other precautions.”

Additional information, including specific exemptions are outlined also.

The following general infection prevention and control measures should be followed:

- **Hand hygiene** - use handwashing facilities (or where this is not available, alcohol based hand rub) before and after journeys.
- **Catch coughs and sneezes** in tissues or cover mouth and nose with sleeve or elbow (not hands); dispose of the tissue into a bin and wash hands immediately.
- **Practice physical distancing**, for example, sit or stand approximately 2 metres from other passengers, travel in larger vehicles where possible or use vehicles with cab
screens, if available. Car-sharing between non-householders must be carefully considered.

- If using public transport, try to avoid busier times of travel to maximise practising physical distancing. Use a face covering.
- Clean vehicles between different drivers or passengers, as appropriate.
- See Transport Scotland’s [advice on how to travel safely](https://www.gov.scot) for further information.
- Do not attend work or use public transport if displaying any COVID-19 symptoms.

### 17. Visiting care homes

The Scottish Government has produced [COVID-19: adult care homes visiting guidance](https://www.gov.scot) which outlines a staged approach to the re-introduction of extended visiting to adult care homes. The phasing allows for increased numbers of visitors, frequency of visits and outdoor and window visits progressing to indoor visits over time. A staged process for a return to communal life will be possible in the next phase, providing there is no ongoing outbreak.

Meantime visitors must be informed of and adhere to IPC measures in place, including face coverings, hand hygiene, physical distancing and not attending 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. A log of all visitors must be kept, which may be used for [Test and Protect](https://www.gov.scot) purposes. Non-essential visiting can be suspended if an outbreak is declared by the local HPT.

Efforts must continue to be made to allow 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.

This guidance on visiting takes a precautionary approach in relation to care homes where there has been infection and advises that 28 days must elapse from the last COVID-19 case. This should not be confused with the minimum 14 day period from the last unprotected exposure to a case or significant PPE breach used by HPTs in consideration of declaring the end of an outbreak.

The relaxation of visiting restrictions in care homes is contingent on a risk assessment process requiring support from the local Care Home partnership oversight group. See the Scottish Government [Coronavirus (COVID-19): clinical and practice guidance for adult care homes](https://www.gov.scot) for further details.

### 18. Caring for a resident who has died

The IPC measures described in this document continue to apply whilst the resident who has died remains in the care home. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower following death. Where the deceased was known or suspected to have been infected with COVID-19, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted. Body bags may be used for other practical reasons such as maintaining dignity or preventing leakage.
For further information, please see the following guidance produced by Scottish Government
Coronavirus (COVID-19): guidance for funeral directors on managing infection risks
when handling the deceased and funeral services.

19. 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 21 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.

1. where the deceased was resident in a care home (this includes residential homes for
   adults, the elderly and children) when the virus was contracted

2. 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 03001231898 or dcrs@nhs24.scot.nhs.uk and authorise disposal of
repatriations to Scotland.
Annex: 1: Organisational and workplace arrangements during COVID-19

This annex contains general advice for workplaces and applies to a range of settings, therefore may be relevant to care homes. For further information, see the COVID-19: guidance for non-healthcare settings.

All organisations and individuals must ensure that they adhere to up to date guidance on recommended public health measures from Scottish Government. Consider which groups of people (e.g. staff, contractors, volunteers, service users and visitors) need to be included in applying guidance to your setting. Consider which of the services or activities provided in your setting are essential. The key public health measures to reduce the spread of infection and preventing infection in vulnerable people are described in detail on NHS Inform.

1. Physical distancing and staying safe guidance

Ensure that all members of the organisation are aware of the requirement to follow physical distancing and staying safe guidance and support them in doing this. Consider the additional demands that will be placed on people and your organisation by following advice on physical distancing and put in place resilience planning to support this.

Staying safe guidance is in place for everyone. Scottish Government COVID-19: returning to work safely states:

“employees should work from home, wherever possible”.

Where the work cannot be done from home then physical distancing must be followed. Individuals who are at increased risk of infection are advised to follow the physical distancing advice stringently and this must be taken into consideration.

It is essential that the clear recommendation of the 2 metre rule outlined in the physical distancing guidance is adhered to. For work designated as essential, there are however circumstances where the 2 m rule cannot be followed despite all possible steps being taken to try to maintain this; in those circumstances a risk based approach should be used. A risk assessment should be conducted that considers the following aspects and the outcome should be documented:

- Is it an essential role (see key worker guidance)
- Is the task being done essential?
- Is it essential that the task is done now or can it be deferred?
- Can the task be done in a different way so that 2 metre distance can be maintained?
  - Yes – do this and document a justification that describes why the process has changed from usual practice, make sure your usual Health and Safety considerations are applied.
  - No – then adapt the task to ensure physical distancing is adhered to as far as possible and document this.
    - Minimise the time spent at less than 2 metres.
- Maintain 2 metre distance for breaks and lunch
- Maximise the distance, where the 2 metre distance cannot be kept, always ensure the greatest distance between people is maintained
  - Apply environmental changes to minimise contact such as physical barriers, markings or changing placement of equipment or seating (e.g. a screen between staff and customers, or tape markings on the floor to show the 2 metre distance required).
  - Consider changes in working practices (stagger times at which work is done or breaks are taken; restructure work flows to allow for physical distancing to be implemented).
  - Explore where possible how digital processes or systems may replace the need for face-to-face discussion
  - Ensure that good hygiene practices and all infection prevention and control measures are implemented fully.

2. Shielding of extremely high risk individuals

See the information on shielding in section 1 of this guidance. Further information on shielding is available in the Scottish Government COVID-19: shielding support and contacts guidance and NHS Inform.

3. Stay at home guidance for people who have symptoms or have a COVID-19 diagnosis (whether they have symptoms or not), and their household members (household isolation)

Organisations must ensure that all members of the organisation are aware that they must stay at home if they develop symptoms of COVID-19 or have a COVID-19 diagnosis (whether or not they have symptoms) and they should support them in doing this. Further details are available on NHS Inform.

Staff should not return to work until symptoms resolve (apyrexial for at least 48 hours), with the exception of cough and loss of/ change in taste or smell, as these symptoms may persist for several weeks. Staff should only return to work when they are feeling clinically better and have completed their self-isolation period. Further information on when to return to work is available on NHS Inform.

Organisations must also ensure that individuals who live in the same household as someone who develops symptoms of COVID-19 or has a COVID-19 diagnosis (whether or not they have symptoms) follow household isolation ‘stay at home’ advice on NHS Inform and be supported to do so.

4. Test and Protect

Organisations should be aware of up to date advice on the Test and Protect (TaP) approach, and should support implementation of this. The Scottish Government have produced COVID-19: Test and Protect advice for employers. Further information is available from the Scottish Government website and NHS Inform.
An individual risk assessment will be undertaken with guidance from the local HPT to identify if employees should be considered as a contact of a COVID-19 case. Employers should put in place physical distancing and hygiene measures as set out in this guidance, and refer to PPE at work section of the COVID-19: guidance for non-healthcare settings for advice on the use of PPE in workplaces that are non-healthcare settings.

5. Infection prevention and control (hygiene measures)

Organisations should:

- Promote good hand hygiene for all staff, volunteers, contractors, service users and visitors.
- Ensure that adequate facilities are available for hand hygiene, including handwashing facilities that are adequately stocked or alcohol based hand rub at key areas (e.g. communal areas and entry and exit points).
- Ensure workers are aware they must not attend work with COVID-19 symptoms or if they have a COVID-19 diagnosis (whether they have symptoms or not). They must also not attend work if they are required to self-isolate through Test and Protect measures.
- Ensure that everyone knows what to do if someone becomes symptomatic whilst at work.
- Ensure regular detergent cleaning schedules and procedures are in place using a product which is active against bacteria and viruses.
  - Ensure regular (at least twice daily) cleaning of commonly touched objects and surfaces (e.g. telephones, keyboards, door handles, desks and tables).
  - Ensure that where possible movement of individuals between work stations is minimised. Where work spaces are shared make sure there is cleaning between use and ensure there are adequate disposal facilities (e.g. avoid hot desks and instead each individual has a designated desk).
  - Wedging doors open, where appropriate, to reduce touchpoints. This does not apply to fire doors.
  - Set clear use and cleaning guidance for toilets to ensure they are kept clean and physical distancing is achieved as much as possible.
  - Clean work vehicles, between different passengers or shifts as appropriate.
- Ensure any crockery and cutlery in shared kitchen areas is cleaned with warm general purpose detergent and dried thoroughly before being stored for re-use.
- Ensure good ventilation (e.g. keep windows open where appropriate).
- Ensure that individuals are aware of and able to follow the hygiene advice.

Ensure that individuals follow the “personal or work travel and physical distancing” guidance.
## Appendix 1 - Contact details for local Health Protection Teams

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Office Hours Telephone Number</th>
<th>Out of Hours Telephone Number Ask for Public Health On Call</th>
<th>Health Protection Team Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>01292 885858</td>
<td>01563 521 133 Crosshouse Hospital switchboard</td>
<td><a href="mailto:hpteam@aapct.scot.nhs.uk">hpteam@aapct.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Borders</td>
<td>01896 825560</td>
<td>01896 826 000 Borders General switchboard</td>
<td><a href="mailto:Healthprotection@borders.scot.nhs.uk">Healthprotection@borders.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>01387 272 724</td>
<td>01387 246 246</td>
<td><a href="mailto:dumf-uhb.hpt@nhs.net">dumf-uhb.hpt@nhs.net</a></td>
</tr>
<tr>
<td>Fife</td>
<td>01592 226435</td>
<td>01592 643355 Victoria Hospital switchboard</td>
<td><a href="mailto:hpt.fife@nhs.net">hpt.fife@nhs.net</a></td>
</tr>
<tr>
<td>Forth Valley</td>
<td>01786 457 283 Ask for CPHM on call</td>
<td>01324 566000 Ask for CPHM on call</td>
<td><a href="mailto:FV-UHB.healthprotectionteam@nhs.net">FV-UHB.healthprotectionteam@nhs.net</a></td>
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<tr>
<td>Grampian</td>
<td>01224 558520</td>
<td>0345 456 6000</td>
<td><a href="mailto:grampian.healthprotection@nhs.net">grampian.healthprotection@nhs.net</a></td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>0141 201 4917</td>
<td>0141 211 3600 Garnavel switchboard</td>
<td><a href="mailto:phpu@ggc.scot.nhs.uk">phpu@ggc.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Highland</td>
<td>01463 704886</td>
<td>01463 704 000 Raigmore switchboard</td>
<td><a href="mailto:hpt.highland@nhs.net">hpt.highland@nhs.net</a></td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>01698 858232 / 858228</td>
<td>01236 748 748 Monklands switchboard</td>
<td><a href="mailto:healthprotection@lanarkshire.scot.nhs.uk">healthprotection@lanarkshire.scot.nhs.uk</a></td>
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<td>Lothian</td>
<td>0131 465 5420/5422</td>
<td>0131 242 1000 Edinburgh Royal switchboard</td>
<td><a href="mailto:health.protection@nhslothian.scot.nhs.uk">health.protection@nhslothian.scot.nhs.uk</a></td>
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<tr>
<td>Orkney</td>
<td>01856 888034</td>
<td>01856 888 000 Balfour Hospital switchboard</td>
<td><a href="mailto:ork-HB.PublicHealth@nhs.net">ork-HB.PublicHealth@nhs.net</a></td>
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<tr>
<td>Shetland</td>
<td>01595 743340</td>
<td>01595 743000 Gilbert Bain switchboard</td>
<td><a href="mailto:shet-hb.PublicHealthShetland@nhs.net">shet-hb.PublicHealthShetland@nhs.net</a></td>
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<tr>
<td>Tayside</td>
<td>01382 596 976/987</td>
<td>01382 660111 Ninewells switchboard</td>
<td><a href="mailto:healthprotectionteam.tayside@nhs.net">healthprotectionteam.tayside@nhs.net</a></td>
</tr>
<tr>
<td>Western Isles</td>
<td>01851 708 033</td>
<td>01851 704 704</td>
<td><a href="mailto:wihealthprotection@nhs.net">wihealthprotection@nhs.net</a></td>
</tr>
</tbody>
</table>
Appendix 2 - Best Practice How to Hand Wash

Steps 3-8 should take at least 15 seconds.

1. Wet hands with water.

2. Apply enough soap to cover all hand surfaces.

3. Rub hands palm to palm.

4. Right palm over the back of the other hand with interlaced fingers and vice versa.

5. Palm to palm with fingers interlaced.

6. Backs of fingers to opposing palms with fingers interlocked.
7. Rotational rubbing of left thumb clasped in right palm and vice versa.

8. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa.

9. Rinse hands with water.

10. Dry thoroughly with towel.

11. Use elbow to turn off tap.

12. Steps 3-8 should take at least 15 seconds.

...and your hands are safe*.
Appendix 3 - Putting on and removing Personal Protective Equipment (PPE)

Putting on PPE

Before putting on PPE:
- Check what the required PPE is for the task/visit (see PPE section)
- Select the correct size of PPE
- Perform hand hygiene

PPE should be put on before entering the room.
- The order for putting on is apron, surgical mask, eye protection (where required) and gloves.
- When putting on mask, position the upper straps on the crown of head and the lower strap at the nape of the neck. Mould the metal strap over the bridge of the nose using both hands.

The order given above is a practical one; the order for putting on is less critical than the order of removal given below.

When wearing PPE:
- Keep hands away from face and PPE being worn.
- Change gloves when torn or heavily contaminated.
- Limit surfaces touched in the care environment.
- Always clean hands after removing gloves

Removal of PPE

PPE should be removed in an order that minimises the potential for cross-contamination.

Gloves
- Grasp the outside of the glove with the opposite gloved hand; peel off.
- Hold the removed glove in gloved hand.
- Slide the fingers of the un-gloved hand under the remaining glove at the wrist.
- Peel the glove off and discard appropriately.

Gown
- Unfasten or break ties.
- Pull gown away from the neck and shoulders, touching the inside of the gown only.
- Turn the gown inside out, fold or roll into a bundle and discard.
Eye Protection
- To remove, handle by headband or earpieces and discard appropriately.

Fluid Resistant Surgical facemask
- Remove after leaving care area.
- Untie or break bottom ties, followed by top ties or elastic and remove by handling the ties only (as front of mask may be contaminated) and discard as clinical waste.
- For face masks with elastic, stretch both the elastic ear loops wide to remove and lean forward slightly. Discard as clinical waste.

To minimise cross-contamination, the order outlined above should be applied even if not all items of PPE have been used.

Perform hand hygiene immediately after removing all PPE.
Appendix 4 - Routine decontamination of reusable non-invasive patient care equipment

- Check manufacturer’s instructions for suitability of cleaning products especially when dealing with electronic equipment.
- Wear appropriate PPE e.g. disposable, non-sterile gloves and aprons.

Is equipment contaminated with blood?

- Yes
  - Immediately decontaminate equipment with disposable cloths/paper roll and a fresh solution of detergent, rinse, dry and follow with a disinfectant solution of \(10,000 \text{ ppm av cl}^*\), rinse and thoroughly dry.
  - Or use a combined detergent/chlorine releasing solution with a concentration of \(1,000 \text{ ppm av cl}^*\), rinse and thoroughly dry.
  - If the item cannot withstand chlorine releasing agents consult the manufacturer’s instructions for a suitable alternative to use following or combined with detergent cleaning.

- No
  - Is equipment contaminated with urine/vomit/faeces or has it been used on a patient with a known or suspected infection/colonisation?

- Yes
  - Immediately decontaminate equipment with disposable cloths/paper roll and a fresh solution of \(1,000 \text{ parts per million available chlorine (ppm av cl)}^*\) rinse and thoroughly dry.
  - If the item cannot withstand chlorine releasing agents consult the manufacturer’s instructions for a suitable alternative to use following or combined with detergent cleaning.

- No
  - Decontaminate equipment with disposable cloths/paper towel and a fresh solution of **general-purpose detergent and water or detergent impregnated wipes**.
  - Rinse and thoroughly dry.
  - Disinfect specific items of non-invasive, reusable, communal care equipment if recommended by the manufacturer e.g. 70% isopropyl alcohol on stethoscopes.

Follow manufacturer’s instructions for dilution, application and contact time.
- Clean the piece of equipment from the top or furthest away point
- **Discard disposable cloths/paper roll immediately into the healthcare waste receptacle**
- Discard detergent/disinfectant solution in the designated area
- Clean, dry and store re-usable decontamination equipment
- Remove and discard PPE
- Perform hand hygiene

* Scottish National Blood Transfusion service and Scottish Ambulance Service use products different from those stated in the National Infection Prevention and Control Manual
Appendix 5: Decontamination and cleaning processes for facilities with possible or confirmed cases of COVID-19

a. In preparation
   - Collect any cleaning equipment and waste bags required before entering the room.
   - Any cloths and mop heads used must be disposed of as single use items.
   - Before entering the room, perform hand hygiene then put on a FRSM, disposable plastic apron and gloves.

b. On entering the room
   - Keep the door closed with windows open to improve airflow and ventilation whilst using detergent and disinfection products.
   - Bag any disposable items that have been used for the care of the patient as clinical waste.

c. Cleaning process
   - Use disposable cloths/paper roll/disposable mop heads, to clean and disinfect all hard surfaces/floor/chairs/door handles/reusable non-invasive care equipment/sanitary fittings in the room, following one of the 2 options below:
     - Use either a combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine (av.cl.)
     - A neutral purpose detergent followed by disinfection (1000 ppm av.cl.).
     - Follow manufacturer’s instructions for dilution, application and contact times for all detergents and disinfectants.
     - Any cloths and mop heads used must be disposed of as single use items.

Cleaning and disinfection of reusable equipment
   - Clean and disinfect any reusable non-invasive care equipment, such as blood pressure monitors, digital thermometers, glucometers, that are in the room prior to their removal.
   - Clean all reusable equipment systematically from the top or furthest away point.

Carpeted flooring and soft furnishings
   - For carpeted floors/items that cannot withstand chlorine-releasing agents, consult the manufacturer’s instructions for a suitable alternative to use following, or combined with, detergent cleaning.
d. On leaving the room

- Discard detergent/disinfectant solutions safely at disposal point.
- Dispose of all waste as clinical waste.
- Clean, dry and store re-usable parts of cleaning equipment, such as mop handles.
- Remove and discard PPE as clinical waste as per local policy.
- Perform hand hygiene.
## Appendix 6: PPE Table 2

### Recommended PPE for primary, outpatient, community and social care by setting, NHS and independent sector

<table>
<thead>
<tr>
<th>Setting</th>
<th>Context</th>
<th>Disposable Gloves</th>
<th>Disposable Plastic Apron</th>
<th>Disposable fluid-resistant coverall/gown</th>
<th>Surgical mask</th>
<th>Fluid-resistant (type III) surgical mask</th>
<th>Filtering face piece respirator</th>
<th>Eye/face protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any setting</td>
<td>Performing an aerosol generating procedure on a possible or confirmed case</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Primary care, ambulatory care, and other non-emergency outpatient and other clinical settings e.g. optometry, dental, maternity, mental health</td>
<td>Direct patient care – possible or confirmed case(s) (within 2 metres)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Individuals own home (current place of residence)</td>
<td>Direct care to any member of the household where any member of the household is a possible or confirmed case</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Direct care or visit to any individuals in the extremely vulnerable group or where a member of the household is within the extremely vulnerable group undergoing shielding</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Community and social care, care home, mental health inpatients and other overnight care facilities e.g. learning disability, hospice, prison healthcare</td>
<td>Facility with possible or confirmed case(s) – and direct resident care (within 2 metres)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Any setting</td>
<td>Collection of nasopharyngeal swab(s)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

1. This may be single use or reusable face/eye protection full face visor or goggles.
2. The list of aerosol generating procedures (AGPs) is included in section 5.1 at: www.gov.uk/government/publications/when-novel-coronavirus-infection-prevention-and-control-19-personal-protection-equipment-type-protection. (Note AGPs are undergoing further review at present).
4. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respiratory after each patient and/or following completion of a procedure, task, or session; disposable or decontamination reusable items offer each patient contact as per Standard Hand Hygiene Protocols (SHPs).
5. A single session refers to a period of time where healthcare worker is undertaking duties in a specific care setting/setting/setting environment e.g. on a ward round; providing emergency care for patients. A session ends when the health care worker leaves the care setting/setting/setting environment.
6. Seasonal use should always be risk assessed and considered where there are high rates of hospital cases. PPE should be disposed of after each session or earlier if damaged, soiled or uncomfortable.
7. Non-essential staff should maintain 1m social distancing, though maintaining a controlled distance, seasonal use should always be risk assessed and considered where there are high rates of community cases.
8. Initial risk assessments should be kept placed by phone prior to entering the premises or within 2 metres social distance on entering, where the health care worker assesses that an individual is symptomatic with suspected confirmed cases appropriate PPE should be put on prior to providing care.
9. Risk reassessment is required to be undertaken PPE when there is an anticipated likely risk of contamination with infectious droplets or blood or body fluids.

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### Additional considerations, in addition to standard infection prevention and control precautions,

where there is sustained transmission of COVID-19, taking into account individual risk assessment for this new and emerging pathogen, NHS and independent sector

<table>
<thead>
<tr>
<th>Setting</th>
<th>Context</th>
<th>Disposable Gloves</th>
<th>Disposable Plastic Apron</th>
<th>Disposable fluid-repellent coverall/gown</th>
<th>Surgical mask</th>
<th>Fluid-resistant (Type III) surgical mask</th>
<th>Filtering face piece respirator</th>
<th>Eye/face protection¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any setting</td>
<td>Direct patient/resident care assessing an individual that is not currently a possible or confirmed case² within 2 metres</td>
<td>✓ single use²</td>
<td>✓ single use²</td>
<td>✗</td>
<td>✗</td>
<td>✓ risk assessment, seasonal use³</td>
<td>✗</td>
<td>✓ risk assessment</td>
</tr>
<tr>
<td>Any setting</td>
<td>Performing an aerosol generating procedure⁶ on an individual that is not currently a possible or confirmed case²⁷</td>
<td>✓ single use²</td>
<td>✗</td>
<td>✓ single use²</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Any setting</td>
<td>Patient transport service driver conveying any individual to essential healthcare appointment that is not currently a possible or confirmed case in vehicle without a bulkhead, no direct patient care and within 2 metres</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>

---

1. This may be single or reusable face/eye protection full face visor or goggles.
3. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator after each patient and/or following completion of a procedure, task, or session. Disposal or decontamination of reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
4. Risk assessment refers to utilising PPE when there is an anticipated low risk of contamination with splashings, droplets of blood or body fluids. Where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid-repellent surgical mask with or without eye protection as determined by the individual staff member for the care episode/single session.
5. A single session relates to a period of time where a health care worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round, providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and considered the risk of infection and from patients, residents and health care workers where COVID-19 is circulating in the community and hospitals. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. The list of aerosol-generating procedures (AGPs) is included in section 8.1 at: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-agps-(note-agps-are-undergoing-a-further-review-at-present)
7. Ambulance staff conveying patients are not required to change or upgrade PPE for the purposes of patient transfer.