Transmission Based Precautions (TBPs) guidance is changing

Please be advised that this document is maintained as a live resource and may be updated periodically to incorporate emerging themes and frequently received enquiries by ARHAI Scotland

Frequently Asked Questions

1. Why are we no longer using droplet and airborne precautions?

The terms droplet and airborne did not fully describe the way infections can spread. Droplet and airborne were categories which assumed infection could only spread in one of these ways. We know this is not the case. In reality, people release a range of particle sizes when they breathe, talk, cough or sneeze which can spread infection both nearby and further away from the infected person. Therefore, there has been a change to the terminology used to describe transmission; droplet and airborne have been replaced with ‘air’ transmission.

2. What are the new respiratory categories?

Instead of droplet or airborne, any infections that can transmit through the ‘air’ (all respiratory infections) have now been sorted into ‘respiratory categories’ according to the hazard they pose. Precautions are now informed by these new respiratory categories. These categories (R1, R2 and R3) allow us to describe the likely outcome of catching one of these respiratory infections. They range from less severe outcomes (R1), to more serious outcomes (R2), to the most severe health outcomes (R3). The categories are also based on the availability of vaccines and medications

Version 1.1, 21 August 2026

to prevent and treat each infection, with R3 infections mainly having very limited vaccines and medications available. The new categories are also based on how likely it is that the infection would spread out of a health and care setting into the wider community. For example, some high consequence infectious diseases (R3) are very likely to spread to the community if they are not well contained.

The new respiratory categories indicate the minimum infection control precautions that should be applied when caring for patients with an R1, R2 or R3 respiratory infection.

For the management of high consequence infectious diseases (HCID), you should continue to refer to the HCID Addendum within the National Infection Prevention and Control Manual.

3. Should precautions still be applied to Aerosol Generating Procedures (AGPs) in practice?

No. The evidence tells us that AGPs do not always represent the highest exposure risk when caring for individuals with respiratory infection. Current evidence demonstrates that coughing (including induced coughing) creates the same amount of (and in some cases even more) airborne particles than AGPs. Because of this, it no longer makes sense to apply precautions just for AGPs.

In light of this evidence, guidance no longer features an AGP list. Instead, the guidance now describes the symptoms and care procedures that are most likely to expose you to the greatest number of respiratory particles. Transmission is only a risk if the individual you are caring for has a suspected or confirmed infection.

4. Why do I now have to put my mask on before entering the room?

This is to prevent you being exposed to any respiratory particles that might be present in the air within the room.

5. If I'm wearing a fluid resistant surgical mask (FRSM), will that be enough to prevent transmission of infection to me?

All aspects of Standard Infection Control Precautions (SIPCs) and Transmission Based Precautions (TBPs) are important in preventing transmission of infection to you and other individuals. You should consider all aspects of these, including hand hygiene, patient placement, cleaning and the use of other types of personal protective equipment, in addition to selecting the right mask.

6. Why does the guidance not advise us to wear RPE for all respiratory infections?

Following completion of the Transmission Based Precautions systematic literature review, the ARHAI Scotland guidance development group considered whether guidance should take a precautionary approach and advise health and care workers to wear RPE for all respiratory infections. The group considered the benefits and harms and concluded that the harms associated with wearing RPE for long periods of time would outweigh the potential benefits, and that surgical masks would continue to provide a level of protection for most infectious agents.

The guidance now advises that you wear RPE when caring for individuals infected with the most hazardous pathogens (R2 and R3 respiratory infectious agents). You may also wear RPE when caring for individuals with R1 infection, if you have a health condition that makes you vulnerable to severe infection outcomes.

Additionally, if you feel worried about being exposed to respiratory infection, you can also make a personal choice to wear RPE instead of a surgical mask when providing care.

7. Do I have to keep my mask on all the time when I'm in a room caring for an individual with a respiratory infection? Is this sessional use?

Yes, keeping the mask on all the time when you are in a room providing care to an individual with respiratory infection may help protect against exposure to any respiratory particles that are in the air.

This can be described as sessional use when a mask is worn continuously when you are caring for more than one infectious individual in the same room (when the individuals are cohorted together), and the mask is only changed if it becomes wet, soiled, or dislodged from your face.

8. Can I keep a mask on when moving between rooms?

Not routinely, even as part of sessional use. There may be occasions where extended use of masks is introduced. Extended use means that masks are worn continuously in all areas of the health and care facility. This might happen during periods of high community infection, for example during winter, but this is not to be done as part of routine practice, and you would be provided with specialist advice on the circumstances where this would apply.

9. I have a health condition that makes me vulnerable to infection, can I choose to wear RPE instead of a fluid resistant surgical mask (FRSM)?

Yes, if you have been advised by your GP, occupational health, or another medical practitioner, then you should wear RPE instead of a FRSM when caring for individuals with respiratory infection.

10. If I choose to wear RPE instead of a fluid resistant surgical mask (FRSM), will my line manager stop me?

No, this is your personal choice. However, you should discuss this with your line manager to ensure they are able to provide the correct mask for you, and you must also be fit tested for an FFP3 respirator.

11. Can I wear an FFP3 respirator without being fit tested first?

No, it is a requirement of the Health and Safety Executive (HSE) that anyone using a FFP3 respirator must be fit tested first and perform a fit check every time you put one on. Fit testing and fit checking makes sure your FFP3 respirator fits properly and forms a good seal on your face, helping to prevent infectious particles from getting in through any gaps.

12. The individual I'm caring for has respiratory symptoms but I don't know what's causing it, what type of mask should I wear?

You should refer to the mask selection algorithm which advises you wear a fluid resistant surgical mask (FRSM) unless you have any information which suggests the individual may have a R2 or R3 pathogen, in which case, wear RPE.

13. Why do I need to wear a mask when I'm caring for an individual in protective isolation?

This is to protect them from any germs you may unknowingly be carrying in your nose or throat.

14. Should I wear eye protection (a face visor, face shield, or goggles) alongside my mask for TBPs?

Not routinely. Each element of personal protective equipment, including eye protection, should be selected based on the task that you are undertaking and the potential for exposure to body fluids.

Eye protection should be compatible with other items of PPE and worn in accordance with manufacturer's instructions. More information for when and where to use PPE is available in the NIPCM/CHIPCM.

15. Should I wear aprons and gloves alongside my mask for TBPs?

Not routinely. Each element of personal protective equipment should be selected based on the task that you are undertaking and the potential for exposure to body fluids. More information for when and where to use PPE is available in the NIPCM/CHIPCM.

16. Should I leave the room vacant after an individual with respiratory symptoms has been discharged, and if so, for how long?

You should wait at least 10 minutes before starting to clean. The 10 minute wait time before cleaning is to allow the largest respiratory particles to settle out from the air onto surfaces, which can then be cleaned.

You may leave the room vacant for longer if the individual was still infectious when vacating the room and if the next room occupant is vulnerable to infection (this may include a patient, resident or a healthcare worker). It is not possible to give a specific timeframe. The risk associated with any particles which may remain in the air will depend on the category of the respiratory pathogen, whether the occupant was still infectious at the time of vacating the room, the vulnerability of the next person entering the room and any ventilation supply to the room. The NHS board IPCT can

help support you when deciding how long to wait and if respiratory protection is required.

17. Appendix 11 used to tell you if the infectious agent was notifiable under the Public Health (Scotland) Act 2008, where can I now find this information?

This information is included within the A-Z of Pathogens in the NIPCM.

18. Where has appendix 15 gone? (the selection of Personal Protective Equipment (PPE) by health and care workers (HCWs) during the provision of care)

The information tables which were contained within Appendix 15 are now within the main body of the NIPCM and CHIPCM.

19. Do we now have to provide visitors with RPE if they are visiting someone with an R2 infection (for example, chickenpox or TB)?

This will depend on whether the visitor is at risk of catching the infection from the individual they are visiting. This may vary depending on the situation. If the visitor has been vaccinated and has already spent time with the infectious individual, they might not need to wear RPE. Visitors should be fit-tested if they are going to wear FFP3 respirators and should be shown how to do a fit-check. If the visitor doesn't want to wear RPE, that is their choice and this should be respected, however you should explain any possible risks and note the outcome in the individual's notes. A visit should not be refused.