Managing children requiring admission to hospital with viral respiratory tract infections: summary flow chart (November 2025)

During periods of high respiratory virus prevalence, cubicles should be prioritised for children at the highest risk of severe disease*

All staff involved in the care of symptomatic children must wear personal protective equipment (PPE) in accordance with appropriate transmission-based precautions.

Child requiring admission to hospital with presumed viral respiratory tract infection

Perform respiratory viral testing (RSV, influenza A/B, SARS-CoV-2). Use rapid molecular testing where locally agreed. If limited testing capacity, prioritise rapid testing for children in whom AGPs are likely to be performed. NOTE: transfer from ED should not be delayed while awaiting viral results

Can initially be admitted to an undifferentiated respiratory bay whilst awaiting respiratory virus results unless AGP being performed (see Appendix 2).

Management of RSV or influenza positive children
Transfer to virus specific cohort bay or cubicle irrespective of whether an AGP is being performed.
De-escalate when appropriate**

Management of RSV or influenza negative children
(these children may be positive for other respiratory viruses including SARS-CoV-2)
Can manage in a non-RSV, non-influenza A/B respiratory cohort area.
De-escalate when appropriate**

*During periods of high prevalence of respiratory viruses, cubicles should be prioritised for the most clinically vulnerable children for protective isolation. This includes children with significant immunosuppression such as severe combined immunodeficiency (until they are immune reconstituted), post BMT: 1st 6 months post allogeneic BMT or 1st 3 months post autologous BMT, post solid organ transplantation: in the first six weeks following solid organ transplants; children with newly diagnosed leukaemia during induction (1st month) or children with relapsed leukaemia (case by case decision based on intensity of treatment for relapse) and children with cystic fibrosis under 2 years of age. The following conditions do not necessarily need isolation for vulnerability; however, clinicians should continue to adhere strictly to IPC guidance as these children are likely to develop severe disease if exposed to respiratory viruses: uncorrected haemodynamically significant congenital heart disease up to 2 years of age; children with pulmonary hypertension up to 2 years of age and children with cardiomyopathy up to 2 years of age; children with chronic lung disease (bronchopulmonary dysplasia) or other lower respiratory tract pathologies necessitating home oxygen or long-term ventilation, up to 2 years of age; children with significant upper airways pathologies requiring ventilatory support, up to 2 years of age; children with severe neuromuscular conditions (i.e. SMA type 1) requiring night-time ventilatory support or regular use of airway clearance technologies such as a cough assist machine/ vest (up to school age).

**Immunocompetent children with respiratory viral infections can be de-escalated from a cubicle/cohort bay after a period of 5 days following the onset of their symptoms. However, children with influenza A or B who are either severely immunocompromised or requiring critical care management should remain in a cubicle or cohort bay for at least 7 days following symptom onset; seek local IPC or virology advice due to risk of prolonged transmission.

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