NHS National Services Scotland

Patient and Resident placement for Isolation and Cohorting Literature Review

Evidence Tables

Version 1.0

2 March 2026

Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) Scotland
An NHS Scotland Assure Service

Version history

This literature review will be updated in real time if any significant changes are found in the professional literature or from national guidance/policy.

Version	Date	Summary of changes
1.0	2 March 2026	First version to accompany version 3.0 of the literature review.

Contents

Introduction

All studies which are critically appraised as part of the literature review are assigned a grade of evidence based on the SIGN50 methodology grading system (SIGN, 2019), which allows scientific studies to be assessed for quality using a number of reviewing forms (available from the SIGN website). Guidelines are appraised and graded using the AGREE II grading system (details available from the AGREE website).

Main conclusions from evidence sources (studies and guidance) are summarised along with a brief description of the methods and limitations within evidence table entries. Evidence sources with sufficient quality, which specifically answer a defined research question, are grouped together to enable the formation of an overall assessment regarding the evidence base.

Evidence grading

The following grades were given to the papers included in this evidence table:

SIGN 50 Evidence Levels

Grade	Description
1++	High quality meta analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
1+	Well conducted meta analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1-	Meta analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2++	High quality systematic reviews of case-control or cohort studies. High quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal
2+	Well conducted case control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal
2-	Case control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal

Grade	Description
3	Non-analytic studies, for example case reports, case series
4	Expert opinion

AGREE II Evidence Levels

Grade	Description
AGREE 'Recommend'	This indicates that the guideline is of high overall quality and can be considered for use in practice without modifications.
AGREE 'Recommend with modifications'	This indicates that the guideline is of moderate overall quality. This could be due to insufficient or lacking information in the guideline for some items. If modifications are made, the guideline could still be considered for use in practice when no other guidelines on the same topic are available.
AGREE 'Do not Recommend'	This indicates that the guideline is of low overall quality and has serious shortcomings. Therefore, it should not be recommended for use in practice.

Research questions for evidence tables

Question 1: How should patients/residents be assessed for infection risk prior to placement within the health and care setting?

Question 2: What different types of isolation areas are there and when should patients/residents be placed in these areas?

Question 3: What is a cohort area, and when should patients /residents be placed in these areas?

Question 4: What is staff cohorting, and when should it be implemented?

Question 5: How should patients/residents be assessed for infection risk prior to discontinuing isolation and cohorting?

Question 1: How should patients/residents be assessed for infection risk prior to placement within the health and care setting?

Evidence added to Literature Review V3.0:

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Carrara E, Ong DS, Hussein K, Keske S, Johansson AF, Presterl E, Tsioutis C, Tschudin-Sutter S, Tacconelli E. ESCMID guidelines on testing for SARS-CoV-2 in asymptomatic individuals to prevent transmission in the health care setting. Clinical Microbiology and	Guideline	**AGREE Recommend with modifications**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Infection. 2022 May 1;28(5):672-80.					

Assessment of evidence

This “guideline addresses the indications for direct testing of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in asymptomatic individuals in health care facilities, with the aim to prevent SARS-CoV-2 transmissions in these settings.”

The guidance makes the following recommendations with regards to asymptomatic testing:

- “The panel suggests immediately testing asymptomatic hospitalized patients who have had high-risk-exposure contacts with SARS-CoV-2 cases, along with isolation in a separate room and close follow-up for symptoms. If negative, patients should be tested again at 5-7 days after contact, regardless of vaccination status (strong recommendation, QoE: very low)
- The panel suggests monitoring for the development of symptoms among low-risk exposure contacts, although if the hospitalized patient population is vulnerable or transmission is likely, testing is recommended (strong recommendation, QoE: very low); if low-risk exposure occurs, patients can be cohorted in the same room or discharged when possible (good practice recommendation)
- The panel suggests immediately testing residents of LTCFs who have had high-risk-exposure contact with SARS-CoV-2 cases, along with isolation in a separate room and close follow-up for symptoms, regardless of vaccination status. The panel suggests testing immediately (at least 2 days after the contact) and, if negative, testing again at 5e7 days after contact (strong recommendation, QoE: very low)”

Limitations

This guideline was generally well done. There was clearly considerable rigour involved in its development and a systematic approach was used to search for evidence. However, there are several limitations:

- No external review by experts before publication

Assessment of evidence
• Opinion of patients (or public) not sought. • The search criteria and search strategy are not provided. • The strengths and limitations of the systematic reviews included in the guidelines are not stated. Although AMSTAR ratings are provided for each, it is unclear what strengths or limitations informed the rating.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organization. Clinical management of COVID-19. Living guideline. 13 January 2023. (Last accessed: 18/08/20205)	Guideline	**AGREE Recommend with modifications**	N/A	N/A	N/A

Assessment of evidence
Objectives: “This guideline aims to be trustworthy and living; dynamically updated and globally disseminated once new evidence warrants a change in recommendations for COVID-19.” The document provides the following **strong recommendations** with regards to initial assessment: “Screen for early recognition of suspected COVID-19 patients and rapid implementation of source control measures

Assessment of evidence

- Screen all persons at first point of contact in health facility to allow for early recognition followed by immediate isolation/separation.

Limitations

- The evidence underlying the recommendations of interest is also unclear as it has not been directly linked to the recommendations within the document.
- The document notes that the WHO commissioned an independent systematic review by the University of British Colombia to consider questions relevant to the present review, but it is not clear how these have been used in the formulation of the recommendations or how the review itself was conducted as the methods are not provided.
- This document has been graded 'Recommend with modifications' because, despite the limitations highlighted, it reflects an up-to-date guideline on a pandemic with many uncertainties – which should be considered when it is used to inform recommendations or good practice points.

NOTE: It should also be noted that this was not the most recent guidance update as of the time of writing. However, it was published on 13 January 2024 and provides the evidence synthesis for the recommendations of interest, which have remained unchanged in the most recent update published on 18 August 2024.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Department of Health & Social Care. Infection prevention and control: resource for adult social care. March 1, 2024 Last accessed January 6, 2025	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

This English guidance “contains general infection prevention and control (IPC) principles to be used in combination with advice and guidance on managing specific infections. It is for those responsible for setting and maintaining standards of IPC within adult social care in England.”

On Assessment, the document states the following:

“An assessment of a person’s risk of infection should be carried out before they start using the service and should be kept under review for as long as they use the service. The assessment should contribute to the planning of the person’s care and should determine whether any extra IPC precautions are required, such as whether they need to isolate or whether workers need to wear additional personal protective equipment (PPE). The assessment should include all factors which place the person at a higher risk of catching or spreading infection and may include:

- Symptoms: history of current diarrhoea or vomiting, unexplained rash, fever or temperature respiratory symptoms, such as coughing or sneezing.

Assessment of evidence
• Contact: previous infection with a multi-drug resistant pathogen (where known), recent travel outside the UK where there are known risks of infection, contact with people with a known infection. • Person risk factors: vaccination status which will assist assessment of their susceptibility to infection and allow protective actions to be taken when necessary, wounds or breaks in the skin, invasive devices such as urinary catheters, conditions or medicines that weaken the immune system. • Environmental risk factors, such as poor ventilation in the care setting” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided. • Applies only to England

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
NHS England. Guidance for risk assessment and infection prevention and control measures for measles in healthcare settings.v1.1	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
March 25, 2024. (Accessed August 19, 2025)					

Assessment of evidence

Objectives: "This guidance is intended to support preparedness for and management of suspected or confirmed measles cases in healthcare settings. It sets out key infection prevention and control (IPC) principles required to prevent transmission of measles in healthcare settings and provides resources to support patient screening, triage, management and assessment of risk applying the hierarchy of controls."

Country: England

The document provides the following on patient placement:

"Patients must be promptly assessed for infection risk on arrival at the care area (for example, inpatient or outpatient) and should be continuously reviewed throughout their stay. The assessment should influence patient placement decisions in line with clinical or care need(s). If a patient is requested to attend secondary care, or requires transfer within a secondary care facility, their infectious status should be communicated to the receiving department.

2.2.1. Patient placement in primary care or outpatient settings

- If remote consultation is not possible or if, following telephone triage, a patient with suspected or confirmed measles is required or advised to attend primary care or outpatient settings, there should be separation in space and/or time between patients. Patients attending with suspected measles infection should be prioritised for assessment/treatment and isolated at the time of arrival (for example, directed to a side room). Appointments should be scheduled to reduce waiting times in reception areas (where necessary) and avoid cross-over of infectious and non-infectious patients.
- If transfer from a primary care facility to a hospital is required, ambulance services should be informed of the infectious status of the patient. Patient confidentiality must be maintained.

Assessment of evidence
2.2.2. Patient placement in accident and emergency departments • Patients attending without prior notification should ideally be screened and triaged at the reception or entrance. • Patients with suspected measles should not wait in communal areas or reception areas and should be placed in a segregated area (ideally a single room away from others) as soon as possible. • If patients with suspected measles arrive in A&E by ambulance, the ambulance service should pre-alert the receiving department to ensure they are admitted directly to a side room or segregated area. • This must not compromise or delay patient care.” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. Management of acute respiratory infection outbreaks in care homes guidance. July 24, 2024. (Last accessed: 18/08/20205)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

"This guidance provides information and advice for health protection practitioners and community infection prevention and control professionals, based in local authorities or in the NHS who have similar responsibilities, and for HPTs in the devolved administrations; when requested to advise on the management of suspected viral ARI outbreaks in Care Quality Commission (CQC) registered care homes for adults in England."

On Isolation

- "Appropriate IPC measures to prevent transmission of infection, including single room dwelling or cohorting, will be continued outside hospital until a minimum of 5 days after the onset of symptoms. Note that in some circumstances (see above) it may be considered necessary to continue infection control measures beyond these periods.

"

On isolation of immunosuppressed residents

Assessment of evidence
"Protection of the immunosuppressed requires consideration. This could potentially be by shielding, sometimes described as reverse isolation or protective isolation. Immunosuppressed residents may also be more infectious, infectious for longer, and more prone to harbour drug resistant viruses. Therefore, it is also important to prevent transmission from these residents to others in the setting" "Post-acute symptoms such as a persistent dry 'post-viral' cough or fatigue do not require ongoing restrictions." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. National Measles guidelines. July 2024. (Accessed August 19, 2025)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This document provides detailed public health guidance on the risk assessment of suspected measles cases, the management of their contacts and a description of the laboratory testing services available to support this."					

Assessment of evidence
On transmission of primary measles, the document states: “Appropriate measures for triage and isolation in health care settings are essential to avoid prolonged exposure to suspected measles cases in waiting areas.” The document also states the following for “Specific settings and situations”: “Primary care settings: Whenever possible, signs should be placed in GP surgery waiting areas advising patients with any rash illness to report to reception. Receptionists should know that any patients with fever and rash are potentially infectious and, ideally, should attend at the end of surgery to minimise the risk of transmission. Where patients with a fever and rash attend when other patients are in the waiting room, they should be directed to a side room. When a GP refers a suspected measles case to A&E or hospital they should inform the hospital staff ahead of time, so that the case can be appropriately isolated on arrival.” Acute hospital settings: “Suspected measles cases that are hospitalised (wards or A&E) need to be appropriately isolated. The hospital Infection Control Team (ICT) should be informed of all suspected measles cases in their Hospital Trust so that they can undertake a risk assessment and provide appropriate advice.” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. *Candidozyma auris*: guidance for acute healthcare settings. August 21, 2025. (Last accessed: September 10, 2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: "It is designed to support the adoption and implementation of the main guidance within acute healthcare settings. This document should be used in conjunction with the main guidance, which provides the supporting evidence and rationale underpinning these recommendations."

Country: England (Guidance has been agreed for use in Scotland by the SHPN "through the agreed review and adoption process" (see Guide for use in Scotland - Public Health Scotland).

The document provides the following on screening

- Screen:
  - ✓ patients who have had an overnight stay in a healthcare facility outside of the UK in the previous year
  - ✓ patients coming from affected units in the UK
- Consider screening patients on high-risk wards or units, subject to local risk assessment.

Assessment of evidence
• Screen contacts of patients with C. auris. • Screen all patients on units or wards with ongoing transmission of cases. • Consider the need to conduct periodic patient screens as part of active surveillance on units or wards where C. auris patients are being managed. **Limitations** • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
European Centre for Disease Prevention and Control. Considerations for infection prevention and control practices in relation to respiratory viral infections in healthcare settings. February 6, 2023.	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
(Last accessed: 18/08/20205)					

Assessment of evidence

This European document “aims to support the development of guidance for healthcare facilities and healthcare providers in the European Union/European Economic Area (EU/EEA) on infection prevention and control (IPC) measures for the management of patients with respiratory tract viral infection in healthcare settings.”

“Testing for the early detection of COVID-19, influenza and RSV cases facilitates both the management of patient admissions and appropriate room and bed allocation in accordance with IPC recommendations.

Universal screening, by testing all patients for SARS-CoV-2 on admission to the hospital irrespective of symptoms to reduce the risk of onward transmission from asymptomatic patients, has limited additional benefit. It may be considered during periods of high community transmission of SARS-CoV-2, in particular by targeting high-risk vulnerable groups (e.g. patients admitted to oncology, transplantation units, etc.) or in the event of emerging viruses with high impact (e.g. emerging SARS-CoV-2 variants with high morbidity and mortality).”

Out-patient Care

“Patients should be asked to contact the primary care practice by phone in advance of a visit and inform them of any respiratory symptoms. If feasible, dedicated home visiting services should be considered for vulnerable patients to avoid crowded out-patient and emergency services.”

“Triage, initial contact and assessment

- Assessment and management of patients with respiratory symptoms should ideally be performed in a separate area of the emergency department. This should allow for the rational use of PPE and the safer collection of diagnostic respiratory samples.

Assessment of evidence

- Other types of exposure (such as travel and contact with animals) should be also considered to allow for prompt testing and isolation of patients with risk factors for infections of high impact such as avian influenza, swine influenza and MERS-CoV."

"Testing

- Rapid antigen detection tests (RADTs) or point-of-care/near-patient tests available for SARS-CoV-2, influenza and - particularly in paediatric care - RSV (separate or combined) for patients with respiratory infection symptoms at emergency departments or entry points to healthcare facilities should be used to support clinical decisions (e.g. triaging, level of protection, isolation and early initiation of antiviral treatment). Early detection of COVID-19, influenza and RSV cases facilitates the optimal management of admitted patients and the appropriate room/bed allocation, in accordance with IPC recommendations.
- Hospitalised patients who present symptoms indicative of respiratory tract infection (fever, cough, sore throat, rhinorrhea) should be tested promptly for respiratory viruses, primarily through molecular tests (e.g. PCR or other NAAT) or point-of-care/near-patient tests, when available. For the diagnosis of SARS-CoV-2 and influenza, a validated rapid antigen detection test (RADT) should be considered to ensure the timely application of IPC measures to prevent onward transmission.

In-patient Care

- "Patients with a confirmed respiratory viral infection, and those with probable respiratory viral infection awaiting confirmatory test results, should ideally be placed in a single room. They should wear a medical face mask when not alone in the room, if tolerated, and practice appropriate hand and respiratory hygiene. If possible, dedicated toilet facilities should be made available.

Limitations

- Method of producing guidance not stated.

Assessment of evidence
• Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organization. Infection Prevention and control in the context of COVID-19: a guideline. 21 December 2023 (Last accessed: 18/08/20205)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence
Objectives: “The objective of this technical guideline is to provide the most up-to-date recommendations for IPC measures to be implemented when caring for people with or managing outbreaks of COVID-19.” Evidence level: This document was graded SIGN50 level 4 because despite describing a good methodology, the evidence underpinning it was gathered using a rapid review. It was not clear which part of the methodology was streamlined or accelerated. The document provides the following recommendations on infection risk assessment before placement in health and care settings:

Assessment of evidence
"Screen for early recognition of suspected or confirmed COVID-19 patients and rapid implementation of source control measures • Use clinical triage1 to assess patients for signs and symptoms of acute respiratory infections, including COVID-19, to prevent transmission to health and care workers. • Promptly isolate/separate patients when appropriate." **Limitations** • Update process or schedule not provided

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organisation. Standard precautions for the prevention and control of infections – Aide Memoire. 20 June 2022.	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This aide-memoire presents a concise overview of important advice for implementation and key elements at a glance." "Healthcare workers should apply source-control measures to individuals with respiratory symptoms (6), including: […]					

Assessment of evidence
• Placing acute respiratory symptomatic patients at least 1 metre (3 feet) away from others in common waiting areas.” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health New Zealand. Candida auris - infection prevention and control guidance for healthcare workers. April 5, 2023. (Last accessed: 18/08/20205)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
This New Zealand “guidance document has been developed using international guidance and resources to help healthcare facilities develop their own policies and procedures based on their environment when providing patient care.” On risk assessment					

Assessment of evidence
"Risk assessment Follow your local policy for screening and identifying patients at risk for C. auris with particular attention to • Received healthcare in an overseas hospital in the last 12 months • Transferred from other health facilities in which known cases have been identified. Liaise with your Infectious Disease team or Clinical Microbiologist regarding specimen collection and laboratory requesting processes." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health New Zealand. COVID-19 infection prevention and control guidance for acute care hospitals. March 2024. (Last accessed: 18/08/20205)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence
Objectives: “This guidance is applicable to all district hospitals that are receiving, assessing, and caring for patients suspected or confirmed to have COVID-19 infection or patients who during risk assessment are identified as being at high risk of COVID-19 infection and outlines the infection prevention and control (IPC) measures to provide a safe workplace for people, patients, and staff in acute care hospitals.” Country: New Zealand. “Risk assessment is a key component to ensuring that patients at high risk of COVID-19 infection are identified on entry to acute care facilities and IPC measures, including isolation, are implemented in timely way to protect HCW’s, patients and visitors. Hospitals should ensure there are clear up-to-date processes in place informing people of the recommended IPC practices to prevent transmission of COVID-19 if they have any of the following criteria • Clinical symptoms of COVID-19, a positive RAT or other COVID-19 viral test - refer to Case definition and clinical testing guidelines for COVID-19 • Household contact of a COVID-19 positive case, or high risk healthcare worker/transmission event.” On Management of Patient exposure events to COVID-19 “All patients admitted to hospital should be assessed to ensure the correct testing criteria is implemented using the COVID-19 Testing Plan for Aotearoa New Zealand or their facility testing plan. Hospitals should have a process in place for managing patients who develop COVID-19 after and during admission. This will include a mechanism to facilitate COVID-19 testing in those that develop compatible symptoms after admission, and early implementation of IPC precautions including patient isolation. Delays in implementing IPC interventions may result in healthcare-acquired COVID-19 transmission to other patients. In this situation the IPC service will need to assess the risk to other patients and develop a plan to manage the exposure event. Factors to consider include but are not limited to: • Movement of the patient to an AIIR, single room or COVID-19 ward/area

Assessment of evidence
• determining the risk of transmission to the other patients by considering the following: ✓ time in the shared space ✓ patient was wearing a mask ✓ physical space – quality of the ventilation, physical distancing between patients, curtains drawn around the bed space etc. ✓ ability to cohort the contacts” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health New Zealand. Interim minimal guidance for MDRO admission screening and placement in a NZ hospital. June 2024.	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
(Last accessed: 18/08/20205)					

Assessment of evidence

Objectives: “This is an interim and initial guide developed in response to reported outbreaks of VRE in the Waikato region (Te Manawa Taki) hospitals and notification of hospital outbreaks of MDROs in Fijian Hospitals. As this is minimum requirements local policies may exceed the below requirements. This document is a living document and will be updated periodically.”

Assessment for infection risk

“Patient assessment, testing and prompt placement in suitable IPC precautions should occur on hospital admission to avoid potential transmission of MDROs. The document also provided a table showing the following scenario/criteria and proffered actions to be taken if the patient meets the scenarios:

A. “Has the patient been admitted for > 24 hours or had a high-risk procedure* in an overseas healthcare facility in the last 12 months? * High risk procedures include, but are not limited to dental procedures, renal dialysis, oncology procedures or gastroscopy.

   AND additional risk factors as below: Endotracheal tube in situ, long term IDC, any wounds, Neonates

B. Has the patient had overseas travel (without healthcare contact) to a South Asian or South-East Asian country in previous 12 months?

   AND additional risk factors as below: Endotracheal tube in situ, long term IDC, any wounds

C. Has the patient been admitted to a NZ hospital or hospital level aged residential care facility/dementia care in last 12 months? NOTE: Screen own hospital readmissions if outbreak has occurred in last 12 months and transmission risks exists.

D. Patient Alert/ NHI national warning for MDRO or MDRO close contact.”

Assessment of evidence
Limitations • Method of producing guidance not stated. • Update process or schedule not provided

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health New Zealand. New Zealand Vancomycin resistant Enterococci (VRE) infection prevention and control guidelines. 12th November, 2024 (Last accessed: 18/08/20205)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: “This guidance document has been developed by the VRE Infection Prevention and Control Technical Advisory Group using international guidance and resources to enable healthcare facilities develop their own policies and procedures based on their environment when providing patient care.”

Country: New Zealand

On VRE assessment

“As a minimum, perform VRE screening on any patient transferred from a healthcare facility with recent/current outbreak/cluster or who have been admitted there within preceding 12 months (as well as screening for other MDRO as appropriate). Some facilities may prefer to screen all patients with admission in the preceding 12 months to any hospital out of district (e.g. another NZ district or an overseas hospital). This includes patients receiving haemodialysis in another district or overseas. Further information available in Appendix 1.”

“Appendix 1: Interim screening recommendations

All acute healthcare facilities should have a policy for screening for MDROs including VRE that is appropriate to their environment and the situation. This could include the need to set up a local or regional IMT. This policy should reference the minimum screening guidance or MDROs linked here.

As a minimum, present recommendations include focus on higher risk situations and areas:

- If VRE has not been identified at your facility, recommend admission screening on patients who have been hospitalised or received haemodialysis in a centre within a transmission risk area within the preceding 12 months (within NZ or overseas).
- Risk assessment and contact tracing should be initiated if a patient is identified with VRE who has not been isolated, and the patient has shared a room or bathroom with others.
- A local or regional outbreak committee should be set up to manage VRE clusters. Additional strategies including regular screening of patients in high risk units may be instituted.

Assessment of evidence

- Admission screening on patients being admitted to ARC, ICU, transplant, haematology or renal unit or any other higher risk units as identified by local IPC service may also be indicated when transmission links are unknown.
- Regular screening of patients receiving on-going medical treatments or interventions or who remain in wards or units identified as a high-risk area or patient.

Screening and testing enable early possible identification of cases and decreases the risk of cross transmission to other susceptible patients.

Routine screening of healthcare staff is not recommended.

People who have had an infection or are colonised with VRE are considered to be colonised indefinitely at this time and must always remain in contact precautions for all hospital admissions."

Assessment depending on size of outbreak and available resources

"Enhanced systematic screening:

- Enhanced screening of at risk populations may be required. Consider regular screening at admission and discharge from high risk units: cancer ward, ICU, NICU, dialysis unit. This should be determined by the Outbreak Management Team or equivalent e.g IPC team.
- Consider one off or regular screening of whole wards or whole hospital to determine unit/facility-level prevalence. This is particularly helpful if VRE identified in clinical New Zealand / VRE Guidelines/ April 2024 pg. 9 specimen(s) from a patient outside of affected area because this indicates high likelihood of undetected cases.
- Prevalence or surveillance screening may be indicated when VRE cases are genomically, but not epidemiologically linked, and contact tracing alone is not controlling the outbreak"

Assessment of evidence
On management of a resident with VRE in Aged and Residential Care Facilities “VRE screening at admission is not routinely required into ARC. It may be required when receiving a resident from a healthcare facility with a VRE cluster or outbreak that has not been completed prior to transfer. Contact the IPC team at the transferring facility. Screening of contacts within an ARC facility is not required unless it is part of an outbreak response. Screening of staff is not required.” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency. Infection Prevention and Control Measures for Respiratory illnesses. March 3, 2023 (Last accessed: 18/08/20205)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence
Objectives: “The IPC principles in this document apply to health and care settings in Northern Ireland and provides guidance for those providing care in non-healthcare settings e.g. community facilities and clients own home. This guidance does not replace existing local protocols that have been developed to support organisations to operationalise other respiratory illness measures.” Country: Northern Ireland On Assessment of High-risk groups/individuals “Groups of individuals at increased risk of complications are those who are suffering from chronic respiratory illnesses, heart disease, chronic renal failure, diabetes, asplenia/splenic dysfunction and frail elderly individuals with comorbidities. A clinical risk assessment is required for those individuals considered to be high risk including if protective isolation is required. Additionally, individuals who are unvaccinated or partially vaccinated are at higher risk of infection and serious illness.” On Triaging/assessment of infection risk “Triaging within all healthcare facilities and non-healthcare facilities, e.g. client’s own home, should continue and be undertaken to enable early recognition of patients with respiratory infectious agents such as influenza or COVID-19. Triage should be undertaken by staff who are trained and competent in the application of clinical case definitions as soon as possible on arrival and used to inform patient placement and what precautions should be implemented. ” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency. Update COVID-19 Testing Arrangements in Care Homes and Hospices. February 29, 2024. (Last accessed: 18/08/20205)	Guidance (Letter to Residential Care Home and Nursing Home Managers and Hospice Directors)	**Level 4**	N/A	N/A	N/A

Assessment of evidence

The following guidance was provided in a letter to care home managers and hospice directors and signed jointly by the Director of Public Health and the Director of Nursing, Midwifery & AHPs.

Country: Northern Ireland

On testing

- "Asymptomatic individuals being admitted from a community setting to a care home for a permanent placement or respite or, hospice setting for symptom management/end of life care do not need to take a test before admission.
- Routine COVID-19 testing of asymptomatic patients who are being discharged from hospital to a care home/hospice is no longer required."

Limitations

- Method of producing guidance not stated.

Assessment of evidence
• Update process or schedule not provided

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. Investigation and initial clinical management of possible human cases of avian influenza with potential to cause severe human disease. Updated 28 February 2024 (Accessed August 19, 2025).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: This document provides recommendations on the investigation and initial clinical management of possible human cases of avian influenza. It also provides some restrictions to its use: “Do not use this guidance document in relation to persons exposed to confirmed detections of avian influenza in avian species in the UK. There is separate guidance for possible human cases that are associated with an incident involving avian species within the UK.”

“Before continuing with the initial assessment

Isolate the patient in a single occupancy room, preferably a respiratory isolation room and ideally under negative pressure; positive pressure rooms must not be used.”

The document also provides the following recommendation if a patient meets the case definition as a possible case:

“patient location – isolate in a single occupancy room to minimise contact or exposure to staff and other patients, preferably a respiratory isolation room and ideally under negative pressure; positive pressure rooms must not be used; patient to minimise contact or exposure to staff and other patients, and ask the patient to wear a surgical mask”

The said case definition is provided below:

“Case definition for possible cases

a) Clinical criteria fever ≥ 38°C or

b) acute respiratory symptoms (cough, hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing or sneezing) or

c) other severe or life-threatening illness suggestive of an infectious process Additionally, patients must fulfil a condition in either category 1 or 2 of the exposure criteria below.

Exposure criteria For H7N9, H9N2, H5N1, H5N6 and any other avian influenza associated with severe human disease:

Assessment of evidence
I. close contact (within 1 metre) with live, dying or dead domestic poultry or wild birds, including live bird markets, in an area of the world affected by avian influenza** or with any confirmed infected animal, in the 10 days before the onset of symptoms or II. in the 10 days before the onset of symptoms, close contact with: • a confirmed human case of avian influenza • human case(s) of unexplained illness resulting in death from affected areas • human cases of severe unexplained respiratory illness from affected areas **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Centers for Disease Control and Prevention. Infection Prevention and Control Strategies for Seasonal Influenza in	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Healthcare Settings. 28 April, 2025. (Last accessed: 18/08/20205)					

Assessment of evidence

Objectives: This American guidance provides recommendations on preventing and controlling influenza in health and care settings.

Country: United States

The document provides the following, amongst other recommendations for the management of patients with influenza symptoms upon arrival to a health or care setting:

- “Provide space and encourage persons with symptoms of respiratory infections to sit as far away from others as possible. If available, facilities may wish to place these patients in a separate area while waiting for care.
- During periods of increased community influenza activity, facilities should consider setting up triage stations that facilitate rapid screening patients for symptoms of influenza and separation from other patients”

Limitations

- Method of producing guidance not stated.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
US Centers for Disease Control and Prevention (CDC). Infection Control Guidance: SARS-CoV-2. June 24, 2024 (Accessed 19 August, 2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: This American guidance "provides a framework for facilities to implement select infection prevention and control practices (e.g., universal source control) based on their individual circumstances (e.g., levels of respiratory virus transmission in the community)."

The document provides the following on patient assessment:

"Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals (e.g., physical barriers at reception/triage locations and dedicated pathways to guide symptomatic patients through waiting rooms and triage areas)."

The document provided the following provisions for specific settings:

"In addition to the recommendations described in the guidance above, here are additional considerations for the settings listed below.

Assessment of evidence
Dialysis Facilities Considerations for Patient Placement • Patients on dialysis with suspected or confirmed SARS-CoV-2 infection or who have reported close contact should be dialyzed in a separate room with the door closed. Hepatitis B isolation rooms can be used if: 1) the patient is hepatitis B surface antigen-positive or 2) the facility has no patients on the census with hepatitis B infection who would require treatment in the isolation room. • If a separate room is not available, patients with confirmed SARS-CoV-2 infection should be cohorted to a specific well-ventilated unit or shift (e.g., consider the last shift of the day). Only patients with confirmed SARS-CoV-2 infection should be cohorted together." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
US Centers for Disease Control and Prevention (CDC). Mpox Infection Prevention and Control in	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Healthcare Settings. July 8, 2025 (accessed August 19, 2025)					

Assessment of evidence

Objectives: This American guidance provides IPC recommendations for the management of Mpox in healthcare settings.

Country: United States of America

On Patient placement, the document states the following:

On duration and discontinuing of isolation precautions, the document states:

“In general, patients in healthcare facilities who have had an MPXV exposure and are asymptomatic do not need to be isolated, but they should be monitored. Monitoring should include assessing the patient for signs and symptoms of mpox, including a thorough skin exam, at least daily, for 21 days after their last exposure. Postexposure risk assessment and management for patients should be adapted from community guidance or healthcare guidance, depending on the nature and location of a patient's exposure.

During the 21-day monitoring period

If a rash occurs, patients should:

- Be placed on empiric isolation precautions for mpox until (1) the rash is evaluated, (2) testing is performed, if indicated, and (3) the results of testing are available and are negative.

If other symptoms of mpox are present, but there is no rash, patients should:

Assessment of evidence
• Be placed on empiric isolation precautions for mpox for 5 days after the development of any new symptom, even if this 5-day period extends beyond the original 21-day monitoring period." "Decisions on whether to isolate exposed patients who are unable to communicate about onset of symptoms should be informed by the risk of their exposure incident (how likely they are to develop mpox), risk that transmission would pose to other patients on their unit (e.g., immunocompromised patients), and other factors." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for Isolation precautions: Preventing	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Transmission of Infectious Agents in Health Care Settings. 2007 (Accessed August 19, 2025).					

Assessment of evidence

This American guideline aims to provide infection control recommendations for all components of healthcare, reaffirm standard precautions as foundation for preventing transmission during patient care, and reaffirm the importance of transmission-based precautions.
The document provides the following on patient assessment for placement:

"V.D.2.d. In ambulatory settings:

- V.D.2.d.i. Develop systems (e.g., triage, signage) to identify patients with known or suspected infections that require Airborne Precautions upon entry into ambulatory settings. Category IA

Limitations:

- Lack of detail provided to determine if a systematic literature review was carried out to obtain evidence.
- May not be fully applicable to Scottish health and care settings.

Evidence from previous update(s):

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Scottish Government. CMO/SGHD(2013) 14: Antimicrobial resistance. August 7, 2013	Letter (DL)	**Mandatory**	N/A	N/A	N/A

Assessment of evidence

This Scottish Government DL was titled ‘Antimicrobial resistance’ and was signed by the CMO, CNO and CPO.

On patient assessment, the document states the following:

"Hospitals should have systems in place to be able to rapidly identify:

- patients who have been transferred from a hospital abroad
- patients who have been hospitalised abroad within the last 12 months
- patients who have previously been positive for CPE at any body site"

Limitations

- There is no clarity on how the guidance provided in the letter was developed.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Scottish Government. Carbapenemase-producing Enterobacteriaceae (CPE) Policy Requirement. March 14, 2013. (Last accessed September 15, 2025).	Letter (DL)	**Mandatory**	N/A	N/A	N/A

Assessment of evidence

This Scottish Government DL was titled ‘Antimicrobial resistance’ and was signed by the CNO.

This DL reinforced the provisions of the previous DL (see above) “The purpose of this letter is to reinforce the mandatory policy requirement for CPE screening in NHS Boards across Scotland. We initially wrote to you in 2013, to request that NHS Boards should have CPE action plans in place and that all patients admitted to acute hospitals should be screened for CPE using an initial clinical risk assessment (CRA).”

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Vonberg, R. P., Kuijper, E. J., Wilcox, M. H., Barbut, F., Tüll, P., Gastmeier, P., ... & Wiuff, C. (2008). Infection control measures to limit the spread of *Clostridium difficile*. Clinical Microbiology and Infection, 14, 2-20.	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: "This literature review and the recommendations contained in these guidelines were stimulated by the increased incidence of *C. difficile*-associated diarrhoea (CDAD) in multiple institutions and countries across Europe. Control measures for *C. difficile* differ in several important ways from those used to reduce the risk of other nosocomial pathogens. We recommend that this document be used to produce and/or review current local protocols for the control of nosocomial CDAD."

Country: Europe

The document provides the following recommendations on patient assessment

Assessment of evidence
“Promptly perform tests for Clostridium difficile toxins (± the bacterium) in stool specimens in each case of nosocomial diarrhoea and for individuals who are admitted with diarrhoea acquired outside the hospital. Stop repeated testing of diarrhoeal stool samples as soon as C. difficile has been diagnosed. Only when a recurrence of CDAD is suspected, repeat the C. difficile testing and exclude other potential causes of diarrhoea.” **Limitations** • Update process or schedule not provided.

Question 2: What different types of isolation areas are there and when should patients/residents be placed in these areas?

Evidence added to Literature Review V3.0:

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
National Institute of Health and Care Excellence. Tuberculosis. January 13, 2016. Last updated February 16, 2024. (Last accessed: August 20, 2025)	Guideline	**AGREE Recommend**	N/A	N/A	N/A
Assessment of evidence					
Objectives: “This guideline covers preventing, identifying and managing latent and active tuberculosis (TB) in children, young people and adults. It aims to improve ways of finding people who have TB in the community and recommends that everyone under 65 with latent TB should be treated. It describes how TB services should be organised, including the role of the TB control board.”					

Assessment of evidence

On Isolation

“Put people with suspected infectious or confirmed pulmonary or laryngeal TB who will remain in a hospital setting (including emergency, outpatients or inpatient care) in a single room. If this is not possible, keep the person's waiting times to a minimum. This may involve prioritising their care above that of other patients. [new 2016]

Minimise the number and duration of visits a person with TB makes to an outpatient department while they are still infectious. To minimise the risk of infection, people with infectious TB should be seen at times or in places away from other people. [new 2016]

In hospital settings, risk assess people with suspected infectious or confirmed pulmonary TB for multidrug-resistant TB (see the section on multidrug-resistant TB). Care for people deemed to be at low risk in a single room, as a minimum. For people deemed to be at high risk:

- provide care in a negative pressure room and
- have specimens sent for rapid diagnostic tests, such as nucleic acid amplification tests. [new 2016]”

“Do not admit people with suspected infectious or confirmed pulmonary TB to a ward containing people who are immunocompromised, such as transplant recipients, people with HIV and those on anti-tumour necrosis factor alpha or other biologics, unless they can be cared for in a negative pressure room on the same ward. [new 2016]”

“If people with suspected or known infectious multidrug-resistant TB are admitted to hospital, admit them to a negative pressure room. If none is available locally, transfer them to a hospital that has these facilities and a clinician experienced in managing complex drug-resistant cases. Carry out care in a negative pressure room for people with:

- suspected multidrug-resistant TB, until non-resistance is confirmed
- confirmed multidrug-resistant TB, until they have 3 negative smears at weekly intervals and ideally have a negative culture. [new 2016]”

Assessment of evidence
"Ensure negative pressure rooms used for infection control in multidrug-resistant TB meet the standards of the Interdepartmental Working Group on Tuberculosis, and are clearly identified for staff, for example by a standard sign. Keep such signs up to date. [2016]" On AGPs "In people who may have TB, only carry out aerosol-generating procedures such as bronchoscopy, sputum induction or nebuliser treatment in an appropriately engineered and ventilated area (ideally a negative pressure room)."

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organization. Clinical management and infection prevention and control of mpox: living guideline. May 2025 (Last accessed 28/08/2025)	Guideline	**AGREE 'Recommend with modifications'**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This document is for public health specialists, health emergency responders, clinicians, health facility managers, health and care workers and IPC practitioners including but not limited to those working in primary care clinics, sexual health					

Assessment of evidence

clinics, emergency departments, dental practices, infectious diseases clinics, genitourinary clinics, maternity services, paediatrics, obstetrics and gynaecology and acute care facilities that provide care for patients with suspected or confirmed mpox."

On Patient placement

"Place patients on contact and droplet precautions for mpox in a single room.

- If a single room is not available or single rooms are limited:
  - ✓ Patients suspected to have mpox and patients deemed as probable mpox cases should be prioritized for a single rooms;
  - ✓ Consider cohorting patients who are confirmed to have mpox.
- Physically separate patients by at least 1 metre (3 feet) and draw privacy curtains.
- Whenever others are in the room and if transport is necessary:
  - ✓ clothing and/or sheet that comfortably covers the lesions.
  - ✓ The patient should wear a wear a medical mask (if able and tolerates) and follow respiratory hygiene and cough etiquette."

"WHO recommends, at the first point of contact with the health system, screening and triage should be performed for all persons who present with a rash and fever and/or lymphadenopathy, according to locally adapted WHO case definition, to identify individuals with suspected or confirmed mpox infection.

- Persons with symptoms that meet the case definition for suspected mpox [108] (see Annex 1: WHO case definitions for mpox outbreak in non-endemic countries) should enter the mpox clinical care pathway and immediately be given a well-fitting medical mask and isolated in a well-ventilated single room. If a well-ventilated single room is not available, then

Assessment of evidence

group patients with similar clinical diagnosis and based on epidemiological risk factors, with a spatial separation (at least 1 metre between patients).

- Suspected cases should not be cohorted together with confirmed cases"

"In patients with suspected or confirmed mpox, WHO suggests that health and care workers use contact and droplet precautions.*

- Consider using a respirator when the ventilation is poor or unknown or based upon a risk assessment (e.g. immunocompromised status or presence of mucosal lesions).
- Airborne precautions should be implemented if varicella zoster virus (i.e. chickenpox) or measles are suspected and until they are excluded.
- Airborne precautions should be implemented when performing aerosol-generating procedures (AGPs).
- If single rooms are not available or in limited supply, cohort confirmed patients and prioritize single rooms for suspect and probable patients."

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organization. Clinical management of COVID-19. Living guideline.	Guideline	**AGREE Recommend with modifications**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
13 January 2023 (Last accessed: 20/08/20205).					

Assessment of evidence

Objectives: “This guideline aims to be trustworthy and living; dynamically updated and globally disseminated once new evidence warrants a change in recommendations for COVID-19.”

The document provides the following strong recommendations with regards to isolation:

“Screen for early recognition of suspected COVID-19 patients and rapid implementation of source control measures Screen all persons at first point of contact in health facility to allow for early recognition followed by immediate isolation/separation.

- Suspected or confirmed COVID-19 patient to wear a medical mask and placement in a separate, well-ventilated area, ideally an isolation room/area if available. Keep at least 1 m distance between patients. Instruct all patients to cover nose and mouth during coughing or sneezing with tissue or flexed elbow, dispose of tissues safely immediately after and perform hand hygiene after contact with respiratory secretions. In areas with COVID-19 community transmission, restrict visitors to those that are essential such as the parents of pediatric patients and caregivers and ask them to wear a mask.”

“Isolate and cohort patients with suspected or confirmed COVID-19

- Where possible, designate a team of health workers to care for patients with suspected or confirmed COVID-19 and restrict their contact with COVID-19 patients.
- Place all cases in well ventilated single rooms if feasible. When single rooms are not available or bed occupancy rate is anticipated to be 100% or more, suspected, probable or confirmed COVID-19 patients should be grouped together (cohorted) in adequately ventilated areas with bed space at least 1 m apart.”

Assessment of evidence
Limitations (and other relevant points) • The evidence underlying the recommendations of interest is also unclear as it has not been directly linked to the recommendations within the document. • The document notes that the WHO commissioned an independent systematic review by the University of British Colombia to consider questions relevant to the present review, but it is not clear how these have been used in the formulation of the recommendations or how the review itself was conducted as the methods are not provided. • This document has been graded 'Recommend with modifications' because, despite the limitations highlighted, it reflects an up-to-date guideline on a pandemic with many uncertainties – which should be considered when it is used to inform recommendations or good practice points. • It should also be noted that this was not the most recent guidance update as of the time of writing. However, it was published on 13 January 2024 and provides the evidence synthesis for the recommendations of interest, which have remained unchanged in the most recent update published on 18 August 2024.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Coia JE, Wilson JA, Bak A, Marsden GL, Shimonovich M, Loveday HP, Humphreys H, Wigglesworth N, Demirjian A,	Guidelines	**AGREE Recommend with modifications**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Brooks J, Butcher L. Joint Healthcare Infection Society (HIS) and Infection Prevention Society (IPS) guidelines for the prevention and control of meticillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities. Journal of Hospital Infection. 2021 Dec 1;118:S1-39.					

Assessment of evidence

Objectives: "The main scope of the guidelines is to provide advice for the optimal provision of an effective and safe healthcare service while reducing the risk of MRSA transmission in healthcare settings. The guidelines are suitable for patients of all age groups. These guidelines were largely developed with hospitals in mind but may be useful in other settings where MRSA is a concern, for example long-stay units. The guidelines' main focus was the prevention of transmission to patients, thus pre and perioperative care was not included."

Assessment of evidence
Country: United Kingdom “11.3 Consider placing patients colonised or infected with MRSA in a single room. The decision to use a single room should be based on a risk assessment that considers the risk of transmission associated with the patient’s condition and the extent of colonisation or infection (e.g. sputum, exfoliating skin condition, large open wounds) and the risk of transmission to other patients in the specific care setting e.g. in burns units. 11.4 Where isolation is deemed necessary, isolate patients for the shortest possible time to minimise feelings of stigma, loneliness, and low mood. 11.5 Provide clear information to patients about the need for the use of protective equipment to reduce feelings of stigma.”

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
MacCannell T, Umscheid CA, Agarwal RK, Lee I, Kuntz G, Stevenson KB, Healthcare Infection Control Practices Advisory Committee. Guideline for the prevention and control of norovirus gastroenteritis	Guideline	**AGREE Recommend with modifications**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
outbreaks in healthcare settings. Infection Control & Hospital Epidemiology. 2011 Oct;32(10):939-69. Last updated February 15, 2017 (Last accessed: 20/08/2025).					

Assessment of evidence

Objectives: “This guideline addresses prevention and control of norovirus gastroenteritis outbreaks in healthcare settings. The guideline also includes specific recommendations for implementation, performance measurement, and surveillance.”

Country: USA

Summary of Recommendations

Patient Cohorting and Isolation Precautions

- Avoid exposure to vomitus or diarrhea. Place patients on Contact Precautions in a single occupancy room if they have symptoms consistent with norovirus gastroenteritis. (Category IB) (Key Question I.A.I)
- When patients with norovirus gastroenteritis cannot be accommodated in single occupancy rooms, efforts should be made to separate them from asymptomatic patients. Dependent upon facility characteristics, approaches for cohorting patients

Assessment of evidence
during outbreaks may include placing patients in multi-occupancy rooms, or designating patient care areas or contiguous sections within a facility for patient cohorts. (Category IB) (Key Question 3C.4.b) **Limitations** • Most of the underpinning evidence for recommendations related to this review was considered low quality. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Marshall C, Richards M, McBryde E. Do active surveillance and contact precautions reduce MRSA acquisition? A prospective interrupted time series. PloS one. 2013 Mar 21;8(3):e58112.	Interrupted time series	**Level 3**	Isolation/cohorting and contact precaution	No isolation/cohorting, no contact precautions	Hazard ratio

Assessment of evidence
Objectives: This Canadian study aimed to evaluate whether the acquisition of MRSA could be reduced by implementing single-room isolation (or cohorting) alongside the use of gloves and gowns for ICU patients colonised or infected with MRSA, compared with a control group where these precautions were not utilised. Setting: Medical-surgical ICU in a 350-bed hospital, which consisted of 24 beds: six single and 18 open-bay. Method: The study employed a prospective interrupted time series design, consisting of two phases. Patients were screened in both phases. In the control phase, results were provided to clinicians, but no specific infection control precautions were implemented. Instead, patients were managed according to standard hospital practice, i.e., staff used plastic aprons for all patient contact. Contact precautions (CP) were rarely used and only in situations where a patient was thought likely to shed high quantities of MRSA, e.g. an MRSA-positive wound with discharge that could not be contained. The patient would be isolated/cohorted alongside CP in such a case. The authors noted, however, that this seldom occurred. In the intervention phase, the results of MRSA screening were transmitted to the ward by phone, and colonised patients were isolated or cohorted immediately alongside the implementation of CP: long-sleeved gowns, gloves. In both phases, all patients were screened using swabs taken from the nose, throat, groin and axilla on admission, Monday, Thursday and at discharge (or within 48 hours of discharge). In the intervention phase, a PCR was also done for each positive test to aid isolation, but it is unclear how these were used. Only culture swabs were, however, used in outcome calculations to avoid detection bias. Hand hygiene was actively promoted, and compliance observations were done for an hour every week on most weeks throughout the study. The hospital policy for hand disinfection was an alcohol-based hand rub solution. Based on power calculations, it was decided that each phase would continue until either 50 acquisition events had been recorded or at least 12 months had passed, whichever was longer. This was needed to detect a significant difference in hazard with a two-tailed p value of 0.05, assuming a hazard ratio of 0.5 with an 80% power. However, a review at 11 months determined that the 50-acquisitions threshold had not been reached, and both phases were reset to a 14-month duration. MRSA acquisition was defined in either of three ways: new colonisation using screening swabs only, i.e. conversion from negative to positive in patients who had two or more swabs, OR new colonisation using screening and clinical specimens, i.e.

Assessment of evidence

initial negative screening and clinical swabs and subsequent positive screening or clinical specimens OR new infection, i.e. one negative screening swab and subsequent infection in patients who had at least one negative set of screening swabs.

A clinical specimen was defined as a specimen sent for a clinical indication. Patients were not included as acquisitions if they had an MRSA-positive clinical specimen in the six months before ICU admission, even if their first set of swabs were negative.

MRSA infection was defined as a sterile site isolate or a non-sterile site clinical isolate, and clinician-administered MRSA-specific antibiotic therapy.

Results: In total, 2183 patients were included in phase 1 and 2196 patients in phase 2, representing 2387 and 2394 admissions, respectively. The number of MRSA acquisitions was 58 (2.7%) in the control phase compared to 27 (1.3%) in the intervention phase. The risk of MRSA acquisition was significantly lower in the intervention phase compared to the control phase, with a hazard ratio of 0.39 (95% CI: 0.24-0.62). Segmented regression model showed a decline in MRSA acquisition of 7% per month in the intervention phase, a significant change in slope compared to the control phase (95% CI: 1.9 – 12.8% reduction).

There was no significant difference in nosocomial MRSA or MSSA bacteremia rates across both phases.

Limitations

- The outcomes for single-room isolation and cohorting were reported together, so it is impossible to tell the differences in their effectiveness.
- The use of PCR to aid isolation was not clearly stated in the paper.

Contribution to study: This study showed that single-room isolation/cohorting alongside contact precautions led to a significant reduction in MRSA acquisition in an ICU setting.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency of Canada. Updated guidance for infection prevention and control in health care settings when COVID-19 is suspected or confirmed. April 2024 (Last accessed: 20/08/2025)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This document updates the previous guidance document …with revised recommendations for: considerations and implementation of masking for source control administrative controls for screening and surveillance of COVID-19 visitation." "This guidance is for all healthcare settings (acute care, long-term care, home care and ambulatory/outpatient care)." Country: Canada On Patient placement "Patient placement and accommodation					

Assessment of evidence
A patient who is suspected or confirmed to have COVID-19 should be cared for in a single room, on precautions with a toilet and sink designated for their use. If no single rooms are available, cohorting patients with confirmed COVID-19 could be considered in consultation with IPC. All facilities should have a pre-established cohorting plan. Clear signage (universal infographics/multilingual as required) indicating Droplet and Contact precautions with appropriate PPE (for COVID-19) should be in place, and posted in such a way that is clearly visible to all entering the patient room or bed space." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency of Canada. Infection prevention and control for COVID-19: Interim guidance for long-term care homes. June 16, 2021. (Last accessed: 20/08/2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: “PHAC is updating its interim guidance on infection prevention and control in long term-care homes (LTCHs) to consider emerging data on the transmission of SARS-CoV-2, the virus that causes COVID-19.”

Country: Canada

On Resident Placement

- “Continued prioritization of single rooms with designated toilets and sinks for residents who are suspected or confirmed to have COVID-19, or those who have had exposure to others with active COVID-19 infection
- Cohorting residents who are confirmed to have COVID-19 in the same room should only be considered when other options are not available, and in consultation with IPC experts. Factors to consider when making decisions about cohorting within a room include:
  - ✓ Availability of single rooms and prioritization based on likelihood of transmission and associated morbidity with COVID-19 and colonization and/or infection with other pathogens that require resident isolation
  - ✓ For SARS-CoV-2, some considerations (where information is available) include: individual and/or community variant risk, status or prevalence, up-to-date information on variant potential for immune-escape, reinfection or superinfection, and time from onset of infection
  - ✓ Anticipated requirement for procedures or situations that may increase risk of pathogen transmission”

“LTCH operators should ensure that:

- …
- Adjustments to the physical layout are made to facilitate IPC measures that prevent transmission of COVID-19 (e.g., single rooms are optimal, spacing chairs and beds a minimum of 2 metres apart in rooms or common areas and staff or break rooms, placing highly visible and accessible spacing indicators on the floors as reminders to maintain physical distancing)

Assessment of evidence

- …
- All AGMPs are performed in an airborne isolation room (AIIR) or private room with the door closed"

"Resident placement and accommodation

The following are important considerations for resident placement and accommodation:

- …The LTCH should be notified of the incoming resident in advance, and screening conducted to rule out signs and symptoms of COVID-19 in the resident
  - ✓ All incoming residents should be admitted to a single room with a dedicated bathroom if available, or a semi-private room with curtains drawn between beds and at least 2 metres between residents
  - ✓ Residents should be placed under isolation on a minimum of Droplet and Contact Precautions for 14 days upon arrival to the facility, and be monitored for development of COVID-19 signs and symptoms, in which case testing should be done promptly. For newly admitted or returning residents who have been fully vaccinated, a shorter duration of isolation may be considered in consultation with IPC experts, and in accordance with jurisdictional guidance. Other factors to be considered include local COVID-19 epidemiology, including of VOCs, any known exposures or outbreak status of sending facility. Testing may also be recommended to reduce risk of COVID-19 introduction into the facility, although a negative admission test alone does not rule out that a resident has been exposed and is in the incubation period
- A resident who is suspected or confirmed to have COVID-19, or who is a high-risk contact of a person confirmed to have COVID-19, should be cared for in a single room with a toilet and sink designated for their use
- …
- Roommates of symptomatic residents should not be moved to new shared rooms, but be placed in a single room for isolation and sign and symptom monitoring

Assessment of evidence
• Clear (multilingual as required) signage should be in place to indicate a minimum of Droplet and Contact Precautions, and posted in such a way that it is clearly visible to all entering the resident room or bed space” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency of Canada. Infection prevention and control for COVID-19: Interim guidance for outpatient and ambulatory care settings. June 16, 2021. (Last accessed: 20/08/2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence
Objectives: “The Public Health Agency of Canada (PHAC) develops evidence-informed infection prevention and control (IPC) guidance to complement provincial and territorial public health efforts in monitoring, preventing, and controlling healthcare-associated infections.” Country: Canada On SARS-CoV-2 variants of concern “Patient placement: Continued recommendation for placement in single rooms for patients who are suspected or confirmed to have COVID-19, or those who have had exposure to others with active COVID-19 infection” On IPC preparedness “Each outpatient and ambulatory care facility should be prepared to identify and manage or otherwise direct patients who are considered exposed to, or suspected or confirmed to have COVID-19. Outpatient and ambulatory care setting operators should ensure that:… • Patients considered exposed to, or suspected or confirmed to have, COVID-19 are immediately placed on a minimum of Droplet and Contact Precautions until COVID-19 or other respiratory infection is ruled out and until criteria for discontinuation of Additional Precautions are met, according to local, provincial and territorial public health and IPC guidance • … • All AGMPs are performed in an airborne isolation room (AIIR) or private room with the door closed.” “Outpatient and ambulatory care settings should minimize access points and ensure that...Access points allow for rapid placement of symptomatic patients under isolation with a minimum of Droplet and Contact Precautions.” “AGMPs are ideally performed in AIIRs if these are available. If a patient requires an AGMP, the patient should at minimum be placed in an AIIR or a private room with the door closed.”

Assessment of evidence
Limitations • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency of Canada. Interim guidance on infection prevention and control for patients with suspected, probable or confirmed mpox within healthcare settings. November 2024. (Last accessed: 20/08/2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence
Objectives: “This guidance intends to provide recommendations for IPC professionals in healthcare settings. Recommendations for non-healthcare settings are beyond the scope of this document.” “This guidance has been updated to reflect the evolving epidemiological situation and advancements in evidence. Key updates to this guidance include: • …Removed recommendation for the use of an airborne infection isolation room (AIIR).” On “Room selection/patient placement The patient should be placed in a single room with the door closed. For inpatients, a dedicated patient bathroom is recommended and commode can be used if dedicated bathroom not available. Intubation, extubation, and any procedures likely to spread oral secretions should be performed in an AIIR.” “Patients with suspected, probable, or confirmed mpox should be immediately placed in a single room with the door closed, for assessment upon entry to the healthcare setting.” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Department of Health. Health Building Note 00-09: Infection control in the built environment. 2013	Expert Opinion	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: “This guidance discusses the various stages of a capital build project from initial concept through to post-project evaluation and highlights the major IPC issues and risks that need to be addressed at each particular stage to achieve designed-in IPC. The principles of this guidance can be applied to all healthcare facilities.” Exclusions: Prison hospitals, operational management of IPC issues such as outbreaks or day-to-day standard IPC precautions. Country: England The document provides the following on the need, types and requirements for isolation facilities: “The role of isolation facilities in preventing cross-infection 3.13 The primary aim of IPC is to prevent the spread of infection between patients, visitors and staff by control or containment of potentially pathogenic organisms. Many of these organisms can be controlled by basic IPC practices such as hand hygiene and environmental cleanliness, and this can be facilitated by single-bed room isolation. A small proportion of patients requiring isolation will require special ventilated isolation facilities.					

Assessment of evidence

3.14 The key to effective isolation on general wards is the provision of sufficient en-suite single-bed rooms to prevent patients known to be a risk for spreading infections being cared for in open ward areas. Single rooms reduce the risk of cross-infection for non-airborne diseases. Most patients needing segregation/isolation on general wards can be isolated effectively in en-suite single rooms.

3.15 A risk assessment should be used to inform decisions regarding which patients to nurse in single bed rooms. Healthcare providers should audit the use of en-suite single-bed rooms to determine where further local requirements and adaptations are greatest.

3.16 Multi-bed rooms can also be used to cohort infectious patients if they have an en-suite WC and shower, and a door to the main ward area. The possible need for this should be considered at the design stage.

3.17 Clinical wash-hand basins should be provided in addition to the general wash-hand basin provided for patients...

3.19 Gloves and aprons should be sited outside single-bed rooms, ideally in lobbies…

3.21 In accident & emergency departments, a dedicated room should be provided for patients with a known or suspected infectious disease. If airborne isolation is required, this room should be at negative pressure to the corridor; a lobby is not required. This room should also be suitable for general use when not required for isolation (see Health Building Note 15-01 – 'Accident & emergency departments')."

"Windows should be sealed and unopenable in operating theatres and special ventilated isolation rooms."

"Smooth jointless impervious ceilings should be used in operating theatres and special ventilated isolation rooms. "

On mental health and learning disability settings, the document notes that "Single rooms can be used for source isolation".

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Department of Health and Social Care. Risk assessment and immediate management of viral haemorrhagic fevers (contact high consequence infectious diseases) in acute hospitals 8 May 2025 (Accessed September 10, 2025)	Expert Opinion	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: “This document provides guidance on the risk assessment and management of patients in the UK in whom infection with a viral haemorrhagic fever (VHF) should be considered or is confirmed. This guidance aims to eliminate or minimise the risk of transmission to healthcare workers and others coming into contact with an infected patient or their samples.” Country: United Kingdom On Single rooms					

Assessment of evidence
"An unwell patient categorised as 'minimal risk of VHF' should be isolated in a single side room to limit contact until the possibility of transmissible infection has been ruled out. The side room should have dedicated en-suite facilities or at least a dedicated commode." "Where a patient is categorised as 'at risk of VHF': • the lead clinician who is responsible for the acute care of the patient should be a senior member of the medical team • the patient should be isolated in a single side room immediately" On HLIU "Where a patient has had a positive VHF test result: • they should be managed in an HLIU, unless exceptional circumstances prevent transfer of the patient" On Patient isolation requirements "**Patient isolation requirements** Experts agree that there is no circumstantial or epidemiological evidence of an airborne transmission risk from VHF patients. A theoretical risk has been postulated. Evidence from outbreaks strongly indicates that the main routes of transmission of VHF infection are direct contact (through broken skin or mucous membrane) with blood or body fluids and indirect contact with environments contaminated with splashes or droplets of blood or body fluids. Avoiding contact with a patient's body fluids, minimising contamination of the environment and safely containing contaminated fluids and materials is paramount to protecting staff and the wider public against infection risks. Following a revised assessment of the risks for the transmission of VHF by the ACDP, this guidance recommends 2 infection control options for the containment and isolation of unwell, infectious VHF patients in the UK. These 2 infection control options provide flexibility in the isolation of a patient with a VHF infection within an HLIU. The particular option used for a patient is decided by the NHS England Contact HCID Network.

Assessment of evidence
Option 1: default option for unwell adult patients VHF patients can be completely isolated using a negative pressure patient bed isolator within a negative pressure isolation suite. Exhaust air from the bed isolator is HEPA (high efficiency particulate air) filtered, as is the exhaust air from the isolation suite, providing additional protection. Staff are protected due to their physical separation from the patient by a flexible film barrier and an air barrier. Access to the patient is via built-in access portholes within the flexible film. The patient isolator will contain all body fluids so that contamination of the isolation suite is minimised. Staff will normally wear theatre scrubs and gloves where necessary and should not require additional PPE if this option is used. **Option 2: preferred option for younger children and certain patient groups, or when option 1 is not feasible** VHF patients can be isolated within a negative pressure isolation suite that has an appropriately designed ventilation system without utilising a bed isolator. Due to the potential for greater exposure to blood and body fluids as a result of ongoing long-term patient management of a confirmed case, staff protection must be provided through the use of PPE that is recommended within the HCID network for the care of patients with confirmed HCIDs. Only staff who are trained and competent in the use of this PPE should be allowed to care for the patient." **Limitations** • A clear methodology for development was not provided. • Update process or schedule not provided

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Department of Health & Social Care. Infection prevention and control: resource for adult social care. March 1, 2024 (accessed August 19, 2025).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: This English guidance "contains general infection prevention and control (IPC) principles to be used in combination with advice and guidance on managing specific infections. It is for those responsible for setting and maintaining standards of IPC within adult social care in England."

Country: England

On Isolation

"The aim of isolation is to prevent spread of infection to others. How this aim is achieved will differ depending on the setting the person is in. During their infectious period, the person should be encouraged to remain in one area, usually their bedroom to reduce the risk of spread to others in their household or care home. People can find it difficult to remain isolated. Where they have the desire and feel able, opportunities to access outside space should be provided. Consideration should be given to distancing measures and restricting mixing with people susceptible to infection, depending on the pathogen causing the infection. Extra cleaning of isolation areas should be considered. Ideally this area will have its own toilet and washing facilities - where this

Assessment of evidence
is not possible, consider a routine for use and cleaning communal or shared facilities. Consideration should be given to any additional PPE.” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
NHS England. Guidance for risk assessment and infection prevention and control measures for measles in healthcare settings.v1.1 24 January 2024 (Last accessed: August 20, 2025).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence
Objectives: “This guidance is intended to support preparedness for and management of suspected or confirmed measles cases in healthcare settings. It sets out key infection prevention and control (IPC) principles required to prevent transmission of measles in healthcare settings and provides resources to support patient screening, triage, management and assessment of risk applying the hierarchy of controls.” Country: England The document provides the following on patient placement: “2.2.2. Patient placement in accident and emergency departments …Patients with suspected measles should not wait in communal areas or reception areas and should be placed in a segregated area (ideally a single room away from others) as soon as possible. If patients with suspected measles arrive in A&E by ambulance, the ambulance service should pre-alert the receiving department to ensure they are admitted directly to a side room or segregated area. This must not compromise or delay patient care. 2.2.3. Patient placement and cohorting in inpatient settings In the hospital setting, patients with suspected or confirmed measles should, whenever possible, be placed in a negative-pressure isolation room with en-suite facilities. If negative-pressure isolation rooms are limited, infectious patients who have conditions that could increase the risk of transmission of infection to other patients (such as an excessive cough) should be prioritised for placement in a single room, ideally with en-suite facilities. Patients should be moved to a negative-pressure isolation room as soon as one becomes available. If a single room or a negative-pressure isolation room is not available, cohort patients with confirmed measles with other patients confirmed to have the same infectious agent. **Limitations** • No methodology for development was provided.

Assessment of evidence
• Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
NHS England. Health Building Note 04-01 Supplement 1: Special ventilated isolation facilities for patients in acute settings. 2024 (Last accessed: September 10, 2025).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: “This document is a supplement to Health Building Note 04-01 – ‘Adult in-patient facilities’ and covers special ventilated isolation facilities only. It should be read in conjunction with HTM 03-01 – ‘Specialised ventilation for healthcare premises’”. Country: England The document provides the following on isolation facilities:					

Assessment of evidence

"Special ventilated isolation rooms: specific requirements

Source airborne isolation (negative pressure isolation suite)

4.31 Specific isolation suite criteria:

- The inflow of air into the room (negative pressure) prevents the escape of contaminated air to surrounding areas; the ventilation in the room dilutes airborne pathogens and contaminants.
- The lobby should be at positive pressure +5 Pa to the corridor. Both the lobby to corridor and the lobby to bedroom doors should open into the lobby and be fitted with door closers. The air pressure in the lobby should help to ensure that the doors remain closed after use.
- Air should be supplied into the lobby and transferred to the bedroom via an above-door pressure stabiliser.
- The bedroom should be at negative pressure: –10 Pa to the lobby.
- The bedroom should be at negative pressure: –5 Pa to the corridor.
- The patient's bedroom will have 10 air changes per hour and be compatible with patient comfort. Airflow should be fully mixed to ensure good dilution and removal of airborne pathogens and contaminants from the room space.
- The en-suite should be at negative pressure to the bedroom.
- The ventilation system has both mechanically supplied and extracted air; these should be interlocked so that, should the extract fail, the supply will cut out (otherwise the room would be under positive pressure).

Note:

The air supply in a typically sized lobby will result in excess of 60 air changes per hour. This will rapidly dilute and remove any airborne contaminants shed when staff doff their PPE."

Assessment of evidence
“Protective airborne isolation (positive pressure isolation suite) 4.32 Specific isolation suite criteria: • The outflow of air from the bedroom (positive pressure) prevents the entry of contaminated air from surrounding areas and purges the lobby. The ventilation in the bedroom dilutes airborne pathogens introduced when staff enter. • The lobby should be at positive pressure +5 Pa to the corridor. • Supply EPA E12 filtered air to provide 10 air changes per hour into the bedroom and transferred to the lobby via an above-door pressure stabiliser set to operate at +5 Pa. • The bedroom air supply should provide comfort conditions in the bedroom. • The lobby to corridor door should open into the lobby and be fitted with a door closer. • The lobby to bedroom door should open into the bedroom and be fitted with a door closer. • The air pressure in the bedroom and lobby should help to ensure that the doors remain closed after use. • The bedroom should be at positive pressure +10 Pa to the corridor and +5 Pa to the lobby. • Air flows from the bedroom to the en-suite at low level via a transfer grille in the en-suite door. • The en-suite should be at negative pressure to the bedroom. • Extract from the en-suite should be through a ceiling-mounted terminal. • The ventilation system has both mechanically supplied and extracted air; these should be interlocked so that, should the supply fail, the extract will cut out (otherwise the room would be under negative pressure)” “Simultaneous source and protective isolation (positive pressure ventilated lobby (PPVL) suite)

Assessment of evidence

4.33 The PPVL is a single room with a positive pressure ventilated entry lobby and en-suite facilities with extract ventilation. The whole suite provides both source and protective isolation. The ventilated lobby ensures that:

- air entering the bedroom is the clean supply from the lobby. Air from the corridor is blocked by the ventilation supply in the lobby; that is, the patient in the bedroom is protected from air entering from the corridor
- potentially contaminated air from the bedroom is prevented from escaping
- into the corridor by the positive pressure ventilated lobby, so the patient will
- not present a risk of infection to others.

4.34 This design enables the suite to be used for both source and protective isolation without the need for switchable ventilation or special training for staff. It also provides safe isolation for patients whose exact condition is unknown. As the lobby simultaneously prevents unfiltered air entering the bedroom and potentially contaminated air escaping from it, the PPVL suite can be used by both infectious patients and those at risk of infection from others.

4.35 Specific isolation suite criteria:

- The outflow of air from the lobby (positive pressure) prevents the entry of contaminated air from surrounding areas; it also purges the lobby and dilutes airborne pathogens introduced when staff enter.
- The lobby should be supplied with filtered air to provide 10 air changes per hour in the bedroom plus an allowance for the lobby to corridor door leakage.
- The air is transferred to the bedroom via an above-door pressure stabiliser set to +10 Pa
- The supply air should provide comfort conditions in the bedroom.
- Both the lobby to corridor and the lobby to bedroom doors should open into the lobby and be fitted with door closers. The air pressure in the lobby should help to ensure that the doors remain closed after use.

Assessment of evidence

- Air flows from the lobby to the bedroom via the high-level pressure stabiliser, circulates around the bedroom and exits via the low-level transfer grille in the en-suite door.
- The lobby should be at positive pressure +10 Pa to the corridor.
- The bedroom should be at neutral pressure 0 Pa to the corridor.
- The en-suite should be at negative pressure to the bedroom.
- Extract from the en-suite should be through a ceiling-mounted terminal.
- The design concept of the PPVL suite provides a robust level of protection to the room occupant should either the supply or extract fan fail. There is therefore no need to interlock the supply and extract fans; however, if either fan fails, it should generate an alarm at both the nurse station and within the estates department so that the fault can be rectified in a timely manner
- The supply air terminal in the lobby ceiling should be of a type that can receive an EPA filter. In general, the EPA filter will not be required and should only be fitted if it is anticipated that immunocompromised patients will be occupying the PPVL suite. The supply fan should be sized to meet the increased system resistance and its output adjusted as necessary when the EPA filter is fitted."

The document provides the following definition for special ventilated isolation facilities

"Special ventilated isolation facilities are those in which the movement of air within the isolation facility will control the ingress and/or egress of airborne harmful pathogens and contaminants. The volume of air delivered and/or removed will dilute the contaminated air and maintain a desired pressure differential between the facility and surrounding areas. The design of the ventilation scheme and correct operation of the facility will ensure that isolation against airborne pathogens or contaminants is maintained even when the door is opened (a) between the lobby and corridor or (b) between the lobby and bedroom.

Assessment of evidence
Note: If the doors between the bedroom and lobby and lobby and corridor are opened simultaneously, or if there is a door between the bedroom and corridor and it is opened, then protection against airborne pathogens or contaminants will not be maintained." The document provides a general design principle and where adaptation may be necessary "While this Supplement focuses specifically on in-patient settings, the overall design principles and intent may be adapted and applied to isolation needs in other departments, particularly emergency departments. Special ventilated isolation facilities consist of a patient's bedroom, lobby and en-suite." The document also provides the following warning: "The provision of isolation rooms that are switchable between positive or negative air pressure is not recommended because of the risk to people inside and outside the room in the event of the setting being incorrect. These should not be included in new or upgraded facilities." The document provides the following reasons to isolate in special ventilated isolation facilities "Reasons to isolate in special ventilated isolation facilities 1.8 It is important to emphasise that clinical decisions around isolation will be made by clinical teams in consultation with IPC teams, but the following are some typical reasons for using a special ventilated isolation facility (see NHS England's 'National infection prevention and control manual for England' for more detailed guidance): • Where a patient has a suspected or confirmed airborne infectious disease or contamination that would be spread by the airborne route (source isolation). • Where a patient is admitted with an infection that is unknown (for example, a patient that has a specific travel history and is presenting with infectious disease symptoms) and which demands one-to-one nursing care until it is clinically safe to move that patient to a more appropriate treatment room or facility (source isolation).

Assessment of evidence

- Where a patient may have become contaminated by a hazardous substance, (source isolation).
- Where a patient is being treated with gene therapy (protective isolation).
- Where a patient is known to be especially susceptible to infection or at risk of contamination from other sources, i.e. immunocompromised (protective isolation)"

The document also provides the following considerations for selecting isolation facilities

- "When designing isolation facilities, a balance needs to be struck between eliminating possible infection risks and increasing the complexity of the design. The higher the complexity, the greater the risk of in-service failure, which would consequently increase the infection risk.
- There are many possible options when specifying room pressures and airflow rates for isolation suites, but complicated schemes that require specialist input for design, commissioning and maintenance have been shown to be unreliable. Furthermore, once commissioned, the rooms are likely to be in use for many years; over time, staff will change, and knowledge of the correct settings and operation may be lost. It is strongly recommended that the designs detailed in this guidance be strictly followed.
- The isolation suite schemes and their detailed designs provided in this Supplement have been selected because they are simple, reliable and robust in operation. The object should be to keep the ventilation systems as simple as possible. Departing from or adding to these designs will not assure a satisfactory outcome."

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. *Candidozyma auris*: guidance for acute healthcare settings. August 21, 2025. (Last accessed: September 10, 2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: "It is designed to support the adoption and implementation of the main guidance within acute healthcare settings. This document should be used in conjunction with the main guidance, which provides the supporting evidence and rationale underpinning these recommendations."

Country: England (Guidance has been agreed for use in Scotland by the SHPN (see Guide for use in Scotland - Public Health Scotland).

The document provides the following on patient placement:

- "Isolate or cohort patients colonised or infected with *C. auris*.
- Use standard infection control and transmission-based precautions (contact precautions) for direct contact with the patient or their immediate environment.

Assessment of evidence
• Use clinical and screening microbiology to guide cohorting decisions, including for other multi-drug resistant organisms (MDROs) as appropriate. • Consider assigning dedicated staff to care for *C. auris* positive patients, particularly during outbreaks." **Limitations** • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. COVID-19: testing for hospices. March 25, 2024 (accessed August 19, 2025).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: This English "guidance sets out how hospices should use COVID-19 lateral flow device (LFD) testing for patient-facing staff presenting with symptoms of COVID-19, how they should access testing for symptomatic patients where having COVID-19 will affect their clinical management, and polymerase chain reaction (PCR) testing during outbreaks of acute respiratory infection." On Isolation, the document states the following:					

Assessment of evidence
"If an individual is tested before discharge into a hospital and tests positive for COVID-19, they can be admitted to the hospice if the hospice is satisfied that they can be cared for safely. Individuals who are admitted with a positive test result should be kept away from other patients on arrival. The period individuals should stay away from others is from the day after the positive test and does not restart when the individual is admitted into the hospice. If the individual has already tested positive before the planned discharge, they do not need to test again if they continue to have symptoms of a respiratory infection and feel unwell or have a high temperature." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. Management of acute respiratory infection outbreaks in care homes guidance. July 24, 2024 (accessed August 19, 2025).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence
Objectives: “This guidance provides information and advice for health protection practitioners and community infection prevention and control professionals, based in local authorities or in the NHS who have similar responsibilities, and for HPTs in the devolved administrations; when requested to advise on the management of suspected viral ARI outbreaks in Care Quality Commission (https://www.cqc.org.uk/) (CQC) registered care homes for adults in England.” Country: England On Isolation “Care home residents admitted to hospital with a diagnosis of influenza, or other respiratory viral infections may remain infectious to others even after discharge from hospital, and IPC measures as outlined in this guidance are indicated to prevent transmission to others. Residents may be discharged from hospital at any point when the following criteria are satisfied. • In the view of the treating clinical staff, the resident has clinically recovered sufficiently to be discharged to a care home. Note that there is no requirement for the resolution of all symptoms or a minimum period of treatment. • All appropriate treatment will be completed after discharge. • Appropriate IPC measures to prevent transmission of infection, including single room dwelling or cohorting, will be continued outside hospital until a minimum of 5 days after the onset of symptoms. Note that in some circumstances (see above) it may be considered necessary to continue infection control measures beyond these periods.” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. National Measles guidelines. July 25, 2024 (Last accessed: 20/08/20205).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: “This document provides detailed public health guidance on the risk assessment of suspected measles cases, the management of their contacts and a description of the laboratory testing services available to support this.” Country: England On transmission of primary measles, the document states: “Appropriate measures for triage and isolation in health care settings are essential to avoid prolonged exposure to suspected measles cases in waiting areas.” The document also states the following for “Specific settings and situations”: “Primary care settings: Whenever possible, signs should be placed in GP surgery waiting areas advising patients with any rash illness to report to reception. Receptionists should know that any patients with fever and rash are potentially infectious and, ideally, should attend at the end of surgery to minimise the risk of transmission. Where patients with a fever and rash attend when other patients are in the waiting room, they should be directed to a side room. When a GP refers a suspected measles case to A&E or hospital they should inform the hospital staff ahead of time, so that the case can be appropriately isolated on arrival.					

Assessment of evidence
When a likely case of measles is reported from primary care, the HPT is responsible for undertaking the public health risk assessment identifying all the likely settings where vulnerable individuals may have been exposed. The HPT will be able to advise on infection control measures and, if for example the patient was not isolated on arrival to a primary care setting and exposed other patients in the waiting room, the surgery will be expected to identify vulnerable patients within the exposure window and clinically assess the risk to each patient based on their vaccine history and underlying condition or treatment." Acute hospital settings: "Suspected measles cases that are hospitalised (wards or A&E) need to be appropriately isolated. The hospital Infection Control Team (ICT) should be informed of all suspected measles cases in their Hospital Trust so that they can undertake a risk assessment and provide appropriate advice." **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
European Centre for Disease Prevention and Control. Considerations for infection prevention and control practices in relation to respiratory viral	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
infections in healthcare settings. February 6, 2023 (accessed August 19, 2025).					

Assessment of evidence

Objectives: This European document "aims to support the development of guidance for healthcare facilities and healthcare providers in the European Union/European Economic Area (EU/EEA) on infection prevention and control (IPC) measures for the management of patients with respiratory tract viral infection in healthcare settings."

Country: EU/EEA

The document notes the following on patient placement:

"Ideally, patients with confirmed respiratory viral infection, or probable respiratory viral infection with confirmatory test results pending, should be placed in a single room. If the number of cases exceeds the single-room capacity, patients with the same viral infection can be placed in the same room (cohorting). Patients with co-infections involving two (or more) respiratory viruses, immunocompromised patients, patients with pronounced symptoms and those requiring bedside procedures associated with a high risk of transmission should be prioritised for placement in single rooms."

In-patient Care

- "Patients with a confirmed respiratory viral infection, and those with probable respiratory viral infection awaiting confirmatory test results, should ideally be placed in a single room. They should wear a medical face mask when not alone in the room, if tolerated, and practice appropriate hand and respiratory hygiene. If possible, dedicated toilet facilities should be made available.

Assessment of evidence

- If the number of patients with respiratory viral infections exceed the single-room capacity of the hospital/facility/ward, patients with the same viral infection can be placed in the same room (cohorting). Patients with co-infections involving two (or more) respiratory viruses, immunocompromised patients, patients with pronounced symptoms and those requiring bedside procedures associated with high risk of transmission should be prioritised for placement in single rooms. Cohorting of patients with suspected respiratory viral infection awaiting diagnostic confirmation alongside other patients with confirmed or suspected infection should be avoided.
- Patients diagnosed with respiratory viral infections that have pandemic potential or are high impact (MERS-CoV, avian influenza) should be prioritised for isolation in a single room or, if available, an airborne-precaution isolation room.
- Intubation for mechanical ventilation should be planned ahead and emergency intubations should be avoided as much as possible. Performing all the necessary procedures, such as central venous catheter and arterial line insertions, during one session should be considered, to conserve PPE.
- Measures to decrease the risk of respiratory virus transmission in healthcare settings include: ensuring appropriate ventilation in patient care areas (at least six air changes per hour in common wards); minimising the contact between patients; ensuring a distance of at least one metre between the beds and considering the use of physical barriers between patients. The use of dedicated (i.e. one for each patient), or if possible, disposable, medical equipment (e.g. blood pressure cuffs, stethoscopes and thermometers), is recommended for patients with COVID-19 or other viral respiratory infections. “

On AGPs, the document states:

“High-risk medical procedures (AGPs) in patients with respiratory viral infections should ideally be performed in a single room and, if possible, in a negative pressure airborne-isolation room. The number of people in the room should be limited to a minimum during such procedures. All those present should wear a well-fitted respirator (see ‘Definitions’), goggles or a visor, a long-sleeved impermeable single-use protective gown and gloves”

Assessment of evidence
Limitations • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
European Centre for Disease Prevention and Control. Investigation Protocol for human exposures and cases of avian influenza in the EU/EEA. 2023 (accessed August 19, 2025).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: This EU “protocol outlines the key steps for case investigation in response to human cases of AIV infection in the European Union and European Economic Area (EU/EEA). It provides guidance for case detection, investigation of other potential cases, testing, contact tracing, case reporting and notification, risk communication and preventive measures. The objective of this					

Assessment of evidence
document is to provide guidance for the investigation and control of a potential avian influenza outbreak in humans. Investigation findings can be used to inform risk assessments." Country: EU/EEA The document provides the following on patient placement for avian influenza: "Cases who need to be hospitalised should preferably be placed in an isolation room with an anteroom and negative pressure or, if not available, in a single room with anteroom and own toilet. Access should be limited to the staff that need to perform tasks." Isolation of contacts in healthcare settings "Contacts can be followed up through daily phone calls or monitoring visits. Since human AIV infections are rare, and the total number of potential close contacts is also likely to be small, stricter monitoring will probably be feasible for public health authorities. However, close contacts may need support to be able to comply with self-quarantine and, in some instances, authorities may decide to admit these individuals to a simple isolation room at a healthcare facility until AIV infection is ruled out." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
European Centre for Disease Prevention and Control. Monkeypox infection prevention and control guidance for primary and acute care settings. August 16, 2022 (accessed August 19, 2025).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: This European document "provides guidance on infection prevention and control (IPC) measures for primary and acute healthcare settings in the European Union/European Economic Area (EU/EEA) to prevent healthcare-associated transmission of monkeypox (MPX)" Country: EU/EEA The document provides the following on placement in primary care settings: "The following IPC guidance refers to the management of patients with compatible history and symptoms of MPX in primary care settings (see case definitions at https://monkeypoxreport.ecdc.europa.eu). These settings vary significantly in the EU/EEA,					

Assessment of evidence

particularly as regards sexual health clinics; as a result, suspected MPX cases may present to various primary settings such as GP offices/clinics and other primary care providers in the community (e.g. dermatologists, paediatricians, etc.)…

During the patient's visit: The patient should be placed in a well-ventilated single exam room with a closed door. The patient should be required to wear a medical face mask."

In Acute care settings

"Patient management

The following measures can be applied to both suspect and confirmed MPX patients in an acute care facility:

- Hospitalisation for MPX cases is not suggested unless their clinical conditions warrant it.
- Patients who need hospitalisation should be placed in a well-ventilated, single room with a dedicated toilet. If single rooms are not available and multiple MPX cases are present, their cohorting can be considered. If varicella zoster virus infection is suspected, precautions for airborne transmission should be maintained until a definitive diagnosis.
- ..
- Aerosol-generating procedures should be performed by personnel wearing appropriate PPE in an airborne isolation room or, if not available, in a well-ventilated single room with a door. The room should then be ventilated, cleaned, and disinfected before it is used for other patients' care."

Limitations

- Method of producing guidance not stated.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organization. Infection Prevention and control in the context of COVID-19: a guideline. 21 December 2023 (Last accessed: 20/08/20205).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: “The objective of this technical guideline is to provide the most up-to-date recommendations for IPC measures to be implemented when caring for people with or managing outbreaks of COVID-19.”

Evidence level: This document was graded SIGN50 level 4 because despite describing a good methodology, the evidence underpinning it was gathered using a rapid review. It was not clear which part of the methodology was streamlined or accelerated.

The document provides the following on placement of patients with suspected or confirmed COVID-19:

- “Isolation is used to separate people with confirmed or suspected COVID-19 from those without COVID-19.
  - A patient with suspected or confirmed COVID-19 should be cared for in a separate, well-ventilated area, preferably in an isolation room or single-patient room, if available.
  - WHO recommendations for the duration of isolation can be found here [52].

Assessment of evidence

- Maintain a physical distance of at least 1 metre between patients, increasing that distance where possible.
- When making decisions about patient placement, health and care workers may consider factors such as the availability of single rooms, and anticipated requirements for procedures or situations that may increase the risk and/or likelihood of transmission.
- Cohorting patients confirmed to have COVID-19 in the same room is a consideration when other options are not available. Patients should stay in their rooms, with restrictions to movement or transport to essential activities."

The document provides the following conditional recommendations on ending isolation:

- "We suggest the use of rapid antigen testing to reduce the period of isolation (very low certainty of evidence)."

Limitations

- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organization. Standard precautions for the prevention and control of infections – Aide Memoire.	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
20 June 2022 (Last accessed: 20/08/20205)					

Assessment of evidence

Objectives: “This aide-memoire presents a concise overview of important advice for implementation and key elements at a glance.”

“Patient placement

- A single room should be used for a patient who poses a risk of transmission to others (for example, if they contaminate the environment or have symptoms of a transmissible infection).”

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organization. Transmission-based precautions for the prevention and control of infections – Aide-memoire. 20 June 2022 (Last accessed: 20/08/20205).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

"Transmission-based precautions are used in addition to standard precautions for patients with known or suspected infection or colonization with transmissible and/or epidemiologically significant pathogens. The type of transmission-based precautions assigned to a patient depends on the transmission route of the microorganism: contact, droplet, or airborne."

""Transmission-based precautions are used in addition to standard precautions for patients with known or suspected infection or colonization with transmissible and/or epidemiologically significant pathogens. The type of transmission-based precautions assigned to a patient depends on the transmission route of the microorganism: contact, droplet, or airborne."

"Transmission-based precautions must be started as soon as a patient presents with symptoms (e.g. fever, new cough, vomiting, diarrhoea). There is no need to wait for test results."

"Placement Place patients according to their symptom presentation:

- Physically separate patients with infectious symptoms from others;

Assessment of evidence
• Prioritize single-patient rooms for patients likely to be most infectious (e.g., coughing, diarrhoea, fever)”.” **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health New Zealand. COVID-19 infection prevention and control guidance for acute care hospitals. March 2024. (Last accessed: 18/08/2025)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: “This guidance is applicable to all district hospitals that are receiving, assessing, and caring for patients suspected or confirmed to have COVID-19 infection or patients who during risk assessment are identified as being at high risk of COVID-19 infection and outlines the infection prevention and control (IPC) measures to provide a safe workplace for people, patients, and staff in acute care hospitals.”					

Assessment of evidence

Country: New Zealand.

On Ventilation and Patient Placement

Patient placement considerations

“Patients with suspected or confirmed COVID-19 infection must be appropriately isolated from other patients who do not have COVID-19 infection until they have been clinically considered non-infectious and can de-isolate as per hospital guidance. Use of negative pressure isolation/airborne infection isolation rooms (AIIR) rooms, single rooms and COVID-19 cohort zones should be based on availability. Rooms should have suitable ventilation and visibility. If available, an AIIR room is recommended. If there is no available AIIR room, a single room with the door closed is an acceptable option. This room should not be positively pressured to the outside corridor. A portable HEPA filtration unit, if available, may be used in this setting to provide an additional measure of infection prevention.

Hospitals should assess how well their facility meets the current minimum ventilation requirements for healthcare settings.

In situations where indoor air quality may be poor, such as single rooms with less than a minimum of 6 air changes per hour, internal rooms with no mechanical ventilation, rooms where windows cannot be opened to allow for air movement or where alternate strategies such as portable filtration units are not available, then consideration should be given to transfer the patient to another area with adequate ventilation controls. In the event of needing to transfer a patient(s) to another area, there should be pathways included in the hospital’s COVID-19 pandemic preparedness planning.

To provide a safe environment in surge situations, additional measures such as the placement of physical barriers e.g. doors, to create cohort areas, the use of portable mechanical ventilation systems, or providing increased physical distancing by limiting the number of occupants in a multi-bedded room may be required. When this situation arises, the IPC Service should be involved in the risk assessment and development of mitigation strategies to minimise the risk of transmission between patients, staff and family/whanau. This process should be clearly documented, recorded on the hospital risk register, reviewed on a regular basis and reverted back to usual processes as soon are allowable.

Assessment of evidence
Patients requiring AGPs with COVID-19 should be prioritised for an AIIR room. This recommendation remains in place while further evidence review is ongoing." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health New Zealand. Infection Prevention and Control. Last updated: June 13, 2025 (Last accessed: 20/08/2025).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: Infection prevention and control guidance for New Zealand. Country: New Zealand The following quotes were extracted from Health New Zealand's 'Infection Prevention and Control' page.					

Assessment of evidence

"Contact Precautions

…The following Contact Precautions apply for all interactions that involve contact with the patient or potentially contaminated objects and surfaces in the patient's environment:…

The patient should be placed in a single room, preferably with its own bathroom. Appropriate signage of PPE requirements should be displayed outside the room."

On airborne precautions, the document states:

"Airborne Precautions are required when interacting with people known or suspected to have diseases spread by very small particles that can suspend in the air and can be inhaled into the lungs.

The following Airborne Precautions apply for all interactions:

- Wear a P2/N95 particulate respirator that you have fit checked before room entry. For guidance on donning, doffing and fit checking, see PPE information on masks, respirators, gloves, aprons and eye protection.
- Where possible, the patient should wear a mask whilst awaiting assessment, or for any movement outside of a single room, along with strict adherence to respiratory hygiene and cough etiquette.

Patients in a hospital setting should be placed within an airborne infection isolation room (negative pressure room). In other settings, the patient should be placed in a single room, preferably with its own bathroom. Appropriate signage of PPE requirements should be displayed outside the room."

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health New Zealand. New Zealand Vancomycin resistant Enterococci (VRE) infection prevention and control guidelines. April 24, 2024 (Last accessed: 20/08/2025)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This guidance document has been developed by the VRE Infection Prevention and Control Technical Advisory Group using international guidance and resources to enable healthcare facilities develop their own policies and procedures based on their environment when providing patient care." Country: New Zealand On Room placement "If VRE identified from screening or from a clinical sample, or if admitting patient with known colonisation or infection with VRE, the following measures are recommended:					

Assessment of evidence

- Patient alert: national alert linked to NHI should be placed on electronic medical record/patient management system for all patients colonised/infected with VRE. Communication between transferring/receiving teams should occur at admission/discharge/transfer.
- Room placement: single room with own toilet facilities is recommended.
  - ✓ A dedicated commode can be used for the duration of the patients hospital stay if no en-suite toilet. Commode to be kept in patients room.
  - ✓ Toilet facilities must not be shared with any patient who does not have VRE.
  - ✓ if no single rooms available cohort with another patient with VRE is acceptable.
  - ✓ Cohorting with patients with other MDROs (especially MRSA) is not acceptable.
  - ✓ If single rooms are limited prioritise those patients who have risk factors for transmission e.g. diarrhoea or uncontained faecal continence, urinary incontinence, discharging wounds that cannot be contained by a dressing.
- Patient movement: Limit patient movement/transfers between rooms/services to only those which are clinically necessary."

Additional core measures for facilities with recent or ongoing VRE outbreak/cluster

- "Implementation of transmission based precautions/room placement: Place VRE cases under contact precautions. Implement cohorting if needed. o Place VRE contacts under pre-emptive contact precautions. Do not cohort with confirmed VRE cases while contact undergoing screening. May be cohorted with other VRE contacts.
  - ✓ Avoid sharing of toilet facilities with any other patients
  - ✓ If not already, consider using disposable antimicrobial curtains."

"Variable measures

Implement enhanced measures depending on size of outbreak and available resources:

Assessment of evidence

- Patient placement/cohorting: if larger numbers of patients affected or cases concentrated to one area, organise outbreak response zones. Arrange 3 dedicated zones (Traffic light system), preferably with dedicated staff ('cohorting') for each zone, if resources allow:
  - ✓ VRE/Red zone: accommodate VRE cases.
  - ✓ Contact/Orange zone: accommodate contact patients without a complete set of negative screening results.
  - ✓ Clear/Green zone: patients who were not contacts or who have tested negative.
- Allied health and visiting clinical teams are asked to group their patient activities to avoid multiple entries in to the VRE/Red zone…
- Transferring patients to other healthcare facility: introduce pre-transfer screening of patients discharging from healthcare facility with VRE outbreak to another hospital or to an ARC facility. Ensure communication of VRE (or screening) status to receiving facility."

Patient placement within healthcare settings

The document provides the following provisions for placement in the following areas

Diagnostic imaging procedures: "Patients may sit in waiting area provided all discharging wounds are covered and patient is continent. Minimise wait times where possible."

Outpatient clinics: "Patients may sit in the waiting area providing all discharging wounds are covered with clean dressing and patient is continent and able to perform hand hygiene before entry to clinic room"

Hospital therapy rooms: "Patients may sit in waiting area provided all discharging wounds are covered and patient is continent."

Patient transfer services: "Where possible dedicated transport should be provided; where not possible, shared transport is acceptable provided all discharging wounds are covered and patient is not incontinent."

On management of a resident with VRE in Aged and Residential Care Facilities

Assessment of evidence

"Residents with VRE should be placed in a single room with an ensuite.

When a single room with an ensuite is not available or sharing a room is unavoidable following a risk assessment consider alternative ways to reduce the risk of transmission, for example,

- Highest priority given to residents who have conditions that may increase the risk of transmission of VRE, for example, faecal incontinence.
- Single room with dedicated bathroom facilities in shared bathroom area, if this is not possible then the bathroom must be cleaned immediately after its use.
- If single room is not possible cohort residents with the same strain of VRE in the same room.
- If cohorting is not possible place in room with resident considered to be low risk (ie. not immunocompromised, without open wounds, drains or indwelling medical devices)
- When sharing a room is required consider the resident with VRE has dedicated bathroom. The bathroom should be cleaned after use or a dedicated commode can be used, with controls in place for emptying and cleaning that avoids environmental contamination.
- If environmental cleaning wipes are used these must not be disposed of in the toilet as this causes blocked drains."

"The decision to isolate a resident should take into account the infection risks to other residents, the presence of risk factors that increase the likelihood of transmission and the psychological effects of isolation on the resident. Contact precautions are intended to be time limited and when implemented include a plan for discontinuation."

Limitations

- Method of producing guidance not stated.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health New Zealand. *Candida auris* - infection prevention and control guidance for healthcare workers. April 5, 2023. (Last accessed: 18/08/2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: This New Zealand "guidance document has been developed using international guidance and resources to help healthcare facilities develop their own policies and procedures based on their environment when providing patient care."

Country: New Zealand

On patient placement, the document states the following:

"Patients should be nursed in a single room that has a dedicated en-suite bathroom. Signage should be visible to all those entering room indicating use of contact precautions and to don the appropriate PPE. As with other multi-drug resistant organisms, patients should be seen last on ward rounds and other service needs, dependent on patient's condition and need."

Limitations

- Method of producing guidance not stated.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health Facilities Scotland. Scottish Health Technical Memorandum 03-01 Specialised ventilation for healthcare premises Part A: The concept, design, specification, installation and acceptance testing of healthcare ventilation systems February 2022 (Last accessed: 20/08/20205).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: “The documents give comprehensive advice and guidance on the legal requirements, design implications, maintenance and operation of specialised ventilation in healthcare premises providing acute care.”					

Assessment of evidence
"Patients who are particularly at risk from airborne microorganisms will normally be placed in an isolation room or suite that is maintained at a positive pressure. Patients who have a condition that could be transmitted to others are normally placed in a negative pressure isolation suite. When the patient's exact condition is unknown they may be placed in a neutral pressure (PPVL) isolation suite." On PPVL "Positive pressure ventilated lobby (PPVL) isolation room Universal isolation facility: Protection of building occupants from patients who may be infected and protection of patients who may be immunocompromised and protection for patients with both conditions. Supply in lobby flowing through a pressure stabiliser to patient's room and on via a door undercut or transfer grille to an extract in the en-suite. Design parameters: Bedroom air change: ≥10 per hour Lobby pressure: +10 Pa to corridor Bedroom pressure: Neutral En-suite pressure: –ve Comfort parameters as above Air quality: BS EN 16798 – SUP2 With facility to fit BS EN 1822 – EPA12" **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. Clade I mpox virus infection.	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Last updated 29 August 2024 (Last accessed: 20/08/2025).					

Assessment of evidence

Objectives: This UK document provides recommendations on certain areas of the management of patients with clade 1 mpox virus infection.

Country: UK

On patient placement, the document provides the following:

“Individuals with clinically suspected mpox presenting to acute care settings who meet the case definition for possible Clade I MPXV infection should be isolated and managed as a HCID as outlined in the NHS guidance on the Infection prevention and control measures for clinically suspected and confirmed cases of mpox in healthcare settings (https://www.england.nhs.uk/long-read/infection-prevention-and-control-measures for-clinically-suspected-and-confirmed-cases-of-mpox-in-healthcare-settings/).

In outpatient settings, individuals presenting with clinically suspected mpox who meet the case definition for possible Clade I MPXV infection should be isolated appropriately (single room, closed door) ...

Where suspected cases meeting the operational case definition present in primary care, General Practitioners should isolate the patient in a single room and contact their local infection service for advice, including appropriate arrangements for transfer into secondary care and immediate precautions in the setting.”

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. Investigation and initial clinical management of possible human cases of avian influenza with potential to cause severe human disease. Updated 15 August 2025 (Last accessed: 20/08/20205).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: This document provides recommendations on the investigation and initial clinical management of possible human cases of avian influenza. It also provides some restrictions to its use: “Do not use this guidance document in relation to persons exposed to confirmed detections of avian influenza in avian species in the UK. There is separate guidance for possible human cases that are associated with an incident involving avian species within the UK.” Country: UK					

Assessment of evidence
"Before continuing with the initial assessment Isolate the patient in a single occupancy room, preferably a respiratory isolation room and ideally under negative pressure; positive pressure rooms must not be used." The document also provides the following recommendation if a patient meets the case definition as a possible case: "patient location – isolate in a single occupancy room to minimise contact or exposure to staff and other patients, preferably a respiratory isolation room and ideally under negative pressure; positive pressure rooms must not be used; patient to minimise contact or exposure to staff and other patients, and ask the patient to wear a surgical mask" **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. UK Guidelines for the management of contacts of invasive group A streptococcus (iGAS) infection in	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
community settings v2.0. March 2023 (Last accessed: 20/08/20205).					

Assessment of evidence

Objectives: “This guidance is for management of cases and contacts of iGAS infection in community settings and supersedes the 2004 interim guidance.”

Country: UK

The documents provided the following on control measures as part of public health actions following a single case of iGAS for Care home settings:

“b) Isolation and exclusion There is inconclusive evidence as to whether the rate of infection or carriage is higher in residents who have close contact with a roommate who is a case or carrier (27). Consider only those sharing a bedroom as ‘household contacts’ and manage according to algorithm 1. Ensure infected residents still residing in the home have their own dedicated equipment and bathroom where practical (or the bathroom should be thoroughly cleaned after each use). There may be no additional benefit in relocating a roommate as they will already have been exposed to the infection. Exclude staff and advise residents with active symptoms of GAS to remain in their room for 24 hours after starting treatment. Staff should remain away from the workplace for at least 24 hours after starting antibiotics, and/or resolution of symptoms. Undertake treatment of infection in liaison with the individual’s GP or healthcare provider. Do not wait for culture results, but ensure antibiotics are appropriate once antimicrobial susceptibility testing results are available. Cases with discharging wounds or ulcers should be isolated until the discharge has ceased and preferably until a swab taken 24 hours after completing antibiotics is negative.”

“Further cases of GAS/iGAS identified: isolate or cohort patients with GAS.”

Assessment of evidence
Limitations • Although the guidance describes its methodology as involving a literature review, very little further detail was provided. Hence, the document was put through as SIGN50 Level 4 expert opinion. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. Framework of actions to contain carbapenemase-producing Enterobacterales. September 2022 (Last accessed: 20/08/20205)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This framework aims to provide health and social care organisations with a useful and pragmatic set of actions to support the implementation and monitoring of interventions to prevent and control the spread of CPE." Country: UK					

Assessment of evidence

"CPE advice for community settings such as care homes, mental health facilities and hospices is provided under the heading of non-acute setting throughout this integrated framework. Key points to consider include:"

The document provides the following on isolation:

"In acute care facilities all inpatients who have been screened for or have confirmed CPE should be managed in a single room with en-suite facilities, where possible. If the single room does not have en-suite facilities, a commode or dedicated toilet should be assigned to the patient...

If single rooms are not available for every screened or known CPE-positive patient a risk assessment should be undertaken by the IPC and clinical teams to determine where to care for patients (38, 39). Single rooms should be prioritised based on:

- patient characteristics, particularly those presenting an increased risk of secondary transmission, such as patients who have diarrhoea, or are incontinent, have wounds with uncontrolled drainage, or are colonised in their respiratory tract and who are coughing
- patient's level of self-care and type of stay (pre-operative, day case, admission or intensive care)
- screening results (high risk patients or confirmed positive)

This also applies to outpatient investigations or procedures, including day surgery unit visits and ambulatory care.

See Appendix E for risk assessment where isolation rooms are limited."

Appendix E: Risk assessment tool for isolating CPE-positive patients (when isolation room capacity is limited) provides the following

- If a patient has diarrhoea (type 6 or 7), they should be 'nursed in a side room on a general ward'.
- If a patient is continent of urine and faeces, alert, orientated, and independently mobile, they should be considered for care in a bay on a general ward.

Assessment of evidence

- If the patient is not continent of urine and faeces but is alert, orientated, and independently mobile, they should be nursed in a side room on a general word.
- If the patient is continent of urine and faeces, independently mobile but is not alert and orientated: “Take into account clinical environment and risk; consider moving patient to an alternative area if confused and unable to comply with isolation in a side room.”
- If the patient is continent of urine and faeces, alert and orientated but not independently mobile, they can be nursed on a bay on a general ward with a dedicated commode.

“Appendix F: Containing CPE in a paediatric setting” provides the following:

“There are several considerations. the key one being that the parent(s) are also likely to be colonised with a CPE and therefore, ensure the baby (with resident mother) is placed in a room with an en-suite for the mother, and their visitors to use. If an en-suite is not available, consider a dedicated toilet”

“4.5.1 Other settings

In outpatient settings and ambulatory care settings, faecally continent patients with CPE who have no other risk factors, present a very low risk of transmission and therefore isolation or cohorting are not routinely required. However, where feasible their close contacts should have their records flagged for admission CPE screening to acute care hospitals. In contrast, CPE colonised patients with diarrhoea pose a greater risk of transmission and, environmental and equipment decontamination will be required following their visit.”

“4.8 Non-acute care settings

…In a shared care environment, a CPE carrier who is not at high risk of spreading CPE to others does not need to be isolated and should be allowed to use communal facilities. If possible, the individual should be accommodated in a single room with en-suite facilities. If not possible, they should not share a room with an immunocompromised individual or those with other risk factors such as chronic wounds.

Assessment of evidence
Those at high risk of infecting others for example with uncontrolled faecal incontinence should have their care activities undertaken in a single room with en-suite facilities. If an en-suite room is not available, the individual should be placed in a single room with a designated commode with easy access to hand washing facilities." **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Centers for Disease Control and Prevention. Expedient Patient Isolation Rooms. October 22, 2024. (Last accessed August 28, 2025)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This guidance is research based and is an effective solution for surge isolation capacity during outbreaks when traditional airborne isolation rooms are not available." Country: United States of America					

Assessment of evidence

The documents provides the following on isolation rooms that can be set up in emergencies when existing capacity is exceeded:

“Oftentimes, local and national protective guidance issued during a pandemic might call upon the use of airborne infection isolation rooms (AIIRs) for patients and/or specific patient procedures. Within U.S. hospitals, AIIRs are patient rooms with specific engineered features, intended to isolate and more-quickly remove potentially infectious patient aerosols. During an epidemic or pandemic, the demand for AIIRs may exceed their availability. When this occurs, healthcare facilities may choose to use portable fan systems with high-efficiency particulate air (HEPA) filtration to establish surge AIIR capacity. Although there is substantial research indicating potential shortcomings when HEPA fan/filter units are deployed incorrectly, there has historically been minimal guidance on how to deploy these units correctly. NIOSH has developed guidance for using portable HEPA filtration systems to create expedient patient isolation rooms. **The Expedient Patient Isolation Room** guidance is researched based and is an effective solution for surge isolation capacity during outbreaks when traditional airborne isolation rooms are not available.

In ventilation system design, a "zone" is a space served by a ventilation system. The expedient patient isolation room approach creates a high-ventilation-rate inner isolation zone that sits within a larger ventilated zone. Contaminated air is contained within the inner zone where it is quickly captured and cleaned while the outer zone remains free of contaminant and is a safer environment for healthcare facility staff, other patients and visitors. **The inner zone is the space immediately surrounding an infectious patient's bed.** The HEPA filtration system is placed between the inner and outer zones. Contaminated air is pulled from the inner zone into the HEPA filtration system, where it is cleaned and then discharged into the outer zone, thus maintaining a negative pressure relationship of the inner zone relative to the outer zone. Using a HEPA filtration system with an air-cleaning capacity to provide at least 12 air changes per hour (ACH) to the overall patient room, this approach results in air-cleaning that's equivalent to a traditional AIIR, while producing an even higher air-cleaning rate within the inner isolation zone. The inner isolation zone boundary is created using a floor-to-ceiling retractable curtain that replaces the traditional patient curtain surrounding the patient bed.

Make-up air into the inner zone flows through a designated curtain gap that also serves as the entrance point into the inner zone. The outer zone is the space between the inner zone and the patient room walls. Depending upon the size of the room, one or two inner zones may be located within the same patient room and share the same outer zone. Air is removed from the inner zone(s)

Assessment of evidence
through the use of a freestanding HEPA filtration system that utilizes a nonducted air inlet. The HEPA system can be positioned to serve up to two patient inner-zones simultaneously, with no exchange of contaminated air between the two inner zones.”

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Center for Disease Control and Prevention. Infection Control Guidance: *Candida auris*. April 24, 2024 (Last accessed: 20/08/2025).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: This American guidance provides recommendations for infection control of *Candida auris* in health and care settings. The document provides the following ‘Considerations for patient room placement’ in ‘Hospitals and nursing homes’: “Patients on Contact Precautions should be placed in a single-patient room whenever possible. In situations where limited single-rooms are available, prioritize placing patients with higher likelihood of transmission (such as those with uncontained secretions or excretions, diarrhea, and draining wounds).					

Assessment of evidence

Facilities can group *C. auris* patients together in a dedicated unit or part of a unit. This decreases movement of healthcare personnel and equipment to non-affected areas. Facilities could also consider dedicating healthcare personnel (e.g., nurses, nursing assistants) who provide regular care to these patients during a shift.

In nursing homes, facilities with the capacity may consider placing patients with *C. auris* in single-patient rooms. Healthcare providers can fi recommendations about patient placement in nursing homes using Enhanced Barrier Precautions (EBP) in CDC's FAQs about Enhanced Barrier Precautions in Nursing Homes.

When single rooms are not available, facilities may choose to cohort patients with *C. auris* together in the same room. It is preferable to cohort patients with the same MDROs together. However, facilities may assign rooms based on single (or a limited number of) high-concern MDROs (e.g., C. auris or carbapenemase-producing Enterobacterales) without regard to co-colonizing organisms."

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
US Centers for Disease Control and Prevention (CDC). Infection Control Guidance: SARS-CoV-2. June 24, 2024 (Accessed 19 August, 2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: This American guidance "provides a framework for facilities to implement select infection prevention and control practices (e.g., universal source control) based on their individual circumstances (e.g., levels of respiratory virus transmission in the community)."

The document provides the following on patient assessment:

"Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals (e.g., physical barriers at reception/triage locations and dedicated pathways to guide symptomatic patients through waiting rooms and triage areas)."

The document provided the following provisions for specific settings:

"In addition to the recommendations described in the guidance above, here are additional considerations for the settings listed below.

Assessment of evidence
Dialysis Facilities Considerations for Patient Placement • Patients on dialysis with suspected or confirmed SARS-CoV-2 infection or who have reported close contact should be dialyzed in a separate room with the door closed. Hepatitis B isolation rooms can be used if: 1) the patient is hepatitis B surface antigen-positive or 2) the facility has no patients on the census with hepatitis B infection who would require treatment in the isolation room. • If a separate room is not available, patients with confirmed SARS-CoV-2 infection should be cohorted to a specific well-ventilated unit or shift (e.g., consider the last shift of the day). Only patients with confirmed SARS-CoV-2 infection should be cohorted together." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
US Centers for Disease Control and Prevention (CDC). Mpox Infection Prevention and Control in	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Healthcare Settings. July 8, 2025 (accessed August 19, 2025)					

Assessment of evidence

Objectives: This American guidance provides IPC recommendations for managing Mpox in healthcare settings.

Country: USA

On Patient placement, the document states the following:

“A patient with suspected or confirmed MPXV infection should be placed in a single-person room; special air handling is not required. The door should be kept closed (if safe to do so). The patient should have a dedicated bathroom...

Intubation, extubation, and any procedures likely to spread oral secretions should be performed in an airborne infection isolation room.”

“In addition to Standard Precautions, if a patient seeking care is suspected to have MPXV infection, additional infection control precautions (as described below) should be implemented. Infection prevention and control personnel should be notified immediately.

Activities that could resuspend dried material from lesions (e.g., use of portable fans, dry dusting, sweeping, vacuuming) should be avoided.”

“In general, patients in healthcare facilities who have had an MPXV exposure and are asymptomatic do not need to be isolated, but they should be monitored. Monitoring should include assessing the patient for signs and symptoms of mpox, including a thorough skin exam, at least daily, for 21 days after their last exposure. Postexposure risk assessment and management for

Assessment of evidence

patients should be adapted from community guidance or healthcare guidance, depending on the nature and location of a patient's exposure.

During the 21-day monitoring period

If a rash occurs, patients should:

- Be placed on empiric isolation precautions for mpox until (1) the rash is evaluated, (2) testing is performed, if indicated, and (3) the results of testing are available and are negative.

If other symptoms of mpox are present, but there is no rash, patients should:

- Be placed on empiric isolation precautions for mpox for 5 days after the development of any new symptom, even if this 5-day period extends beyond the original 21-day monitoring period.
    - If 5 days have passed without the development of any new symptom and a thorough skin and oral examination reveals no new rashes or lesions, isolation precautions for mpox can be discontinued.
    - Isolation precautions may be discontinued prior to 5 days if mpox has been ruled out.
    - If a new symptom develops again at any point during the 21-day monitoring period, then the patient should be placed on empiric isolation precautions for mpox again, and a new 5-day isolation period should begin."

Limitations

- Method of producing guidance not stated.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Center for Disease Control and Prevention. Prevention and Control for Hospitalized MERS Patients. May 30, 2024 (Last accessed: 20/08/2025).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: This American guidance provides recommendations for preventing and controlling MERS in hospitalised patients.

Country: USA

The document states the following on patient placement:

- "Place a patient who might be infected with MERS-CoV in an Airborne Infection Isolation Room (AIIR) that has been constructed and maintained in accordance with current guidelines.
    - AIIRs are single patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation). Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter before recirculation. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized. Facilities should monitor and document the proper negative-pressure function of these rooms.

Assessment of evidence

- If an AIIR is not available, the patient should be transferred as soon as is feasible to a facility where an AIIR is available. Pending transfer, place a facemask on the patient and isolate him/her in an examination room with the door closed. The patient should not be placed in any room where room exhaust is recirculated without high-efficiency particulate air (HEPA) filtration.

- Once in an AIIR, the patient's facemask may be removed; the facemask should remain on if the patient is not in an AIIR. Limit transport and movement of the patient outside of the AIIR to medically-essential purposes. When outside of the AIIR, patients should wear a facemask to contain secretions.
- Only essential personnel should enter the AIIR. Implement staffing policies to minimize the number of HCP who enter the room.
    - Facilities should consider caring for these patients with dedicated HCP to minimize risk of transmission and exposure to other patients and other HCP.
- Facilities should keep a log of all persons who care for OR enter the rooms or care area of these patients.
- Once the patient vacates a room, unprotected individuals, including HCP, should not be allowed in that room until sufficient time has elapsed for enough air changes to remove potentially infectious particles. More information on clearance rates under differing ventilation conditions is available. In addition, the room should undergo appropriate cleaning and surface disinfection before unprotected individuals are allowed to reenter it."

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Center for Disease Control and Prevention. Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) July 12, 2022 (Last accessed: 20/08/2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: This American document is "intended to provide guidance for PPE use and room restriction in nursing homes for preventing transmission of MDROs, including as part of a public health response".

Country: USA

Under contact precaution for MDRO prevention, the document states the following:

"Contact Precautions require the use of gown and gloves on every entry into a resident's room. The resident is given dedicated equipment (e.g., stethoscope and blood pressure cuff) and is placed into a private room. When private rooms are not available,

Assessment of evidence

some residents (e.g., residents with the same pathogen) may be cohorted, or grouped together. Residents on Contact Precautions should be restricted to their rooms except for medically necessary care and restricted from participation in group activities.

Because Contact Precautions require room restriction, they are generally intended to be time limited and, when implemented, should include a plan for discontinuation or de-escalation."

The document also makes the following distinctions between enhanced barrier precautions and contact precautions:

"…Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk."

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Centers for Disease Control and Prevention. Interim Guidance for Infection Control Within Healthcare Settings When	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease. March 9, 2022 (Last accessed August 28. 2025)					

Assessment of evidence

Objectives: This guidance provides recommendations for infection prevention and control in healthcare settings for patients who may be infected with a novel influenza A virus (i.e., an influenza A virus of animal origin that has not recently been circulating among humans) associated with severe disease.

Country: USA

On patient placement, the document states:

“If an AIIR is not available, the patient should be transferred as soon as is feasible to a facility where an AIIR is available. Pending transfer, place a facemask on the patient and isolate him/her in an examination room with the door closed. The patient should not be placed in any room where room exhaust is recirculated without high-efficiency particulate air (HEPA) filtration.”

Assessment of evidence
Limitations • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Centres for Disease Control and Prevention. Infection Prevention and Control Strategies for Seasonal Influenza in Healthcare Settings. May 13, 2021 (Last accessed: 20/08/2025).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: This American guidance provides recommendations for preventing and controlling influenza in healthcare settings. Country: USA					

Assessment of evidence
The document provides the following on placement for suspected or confirmed influenza patients: “Place patients with suspected or confirmed influenza in a private room or area. When a single patient room is not available, consultation infection control personnel is recommended to assess the risks associated with other patient placement options (e.g., cohorting [i.e., grouping patients infected with the same infectious agents together to confine their care to one area and prevent contact with susceptible patients keeping the patient with an existing roommate). For more information about making decisions on patient placement for droplet precautions, CDC HICPAC Guidelines for Isolation Precautions [section V.C.2].” **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for Isolation precautions:	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Preventing Transmission of Infectious Agents in Health Care Settings. Last updated July 2023.					

Assessment of evidence

Objectives: This American guideline aims to provide infection control recommendations for all components of healthcare, reaffirm standard precautions as foundation for preventing transmission during patient care, and reaffirm the importance of transmission-based precautions.

Country: United States of America

The document states the following on patient placement:
"V.B.2. Patient placement

V.B.2.a. In acute care hospitals, place patients who require Contact Precautions in a single-patient room when available [24, 687, 793, 796, 797, 806, 837, 893, 1012, 1013] Category IB When single-patient rooms are in short supply, apply the following principles for making decisions on patient placement:

- V.B.2.a.i. Prioritize patients with conditions that may facilitate transmission (e.g., uncontained drainage, stool incontinence) for single-patient room placement. Category II
- V.B.2.a.ii. Place together in the same room (cohort) patients who are infected or colonized with the same pathogen and are suitable roommates [29, 638, 808, 811-813, 815, 818, 819] Category IB

Assessment of evidence

If it becomes necessary to place a patient who requires Contact Precautions in a room with a patient who is not infected or colonized with the same infectious agent:

- V.B.2.a.iii. Avoid placing patients on Contact Precautions in the same room with patients who have conditions that may increase the risk of adverse outcome from infection or that may facilitate transmission (e.g., those who are immunocompromised, have open wounds, or have anticipated prolonged lengths of stay). Category II
- V.B.2.a.iv. Ensure that patients are physically separated (i.e., >3 feet apart) from each other. Draw the privacy curtain between beds to minimize opportunities for direct contact.) Category II"

"V.C.1. Patient placement

- V.C.1.a. In acute care hospitals, place patients who require Droplet Precautions in a single-patient room when available Category II When single-patient rooms are in short supply, apply the following principles for making decisions on patient placement:
- V.C.2.a.i. Prioritize patients who have excessive cough and sputum production for single-patient room placement Category II
- V.C.2.a.ii. Place together in the same room (cohort) patients who are infected the same pathogen and are suitable roommates [814, 816]. Category IB If it becomes necessary to place patients who require Droplet Precautions in a room with a patient who does not have the same infection:
- V.C.2.a.iii. Avoid placing patients on Droplet Precautions in the same room with patients who have conditions that may increase the risk of adverse outcome from infection or that may facilitate transmission (e.g., those who are immunocompromised, have or have anticipated prolonged lengths of stay). Category II
- V.C.2.a.iv. Ensure that patients are physically separated (i.e., >3 feet apart) from each other. Draw the privacy curtain between beds to minimize opportunities for close contact [103, 104, 410]. Category IB"

Assessment of evidence

- "V.C.1.b. In long-term care and other residential settings, make decisions regarding patient placement on a case-by-case basis after considering infection risks to other patients in the room and available alternatives410. Category II
- V.C.1.c. In ambulatory settings, place patients who require Droplet Precautions in an examination room or cubicle as soon as possible. Instruct patients to follow recommendations for Respiratory Hygiene/Cough Etiquette [447, 448 9, 828]. Category II"

V.D.2. Patient placement

V.D.2.a. In acute care hospitals and long-term care settings, place patients who require Airborne Precautions in an AIIR that has been constructed in accordance with current guidelines11-13. Category IA/IC

- V.D.2.a.i. Provide at least six (existing facility) or 12 (new construction/renovation) air changes per hour.
- V.D.2.a.ii. Direct exhaust of air to the outside. If it is not possible to exhaust air from an AIIR directly to the outside, the air may be returned to the air-handling system or adjacent spaces if all air is directed through HEPA filters.
- V.D.2.a.iii. Whenever an AIIR is in use for a patient on Airborne Precautions, monitor air pressure daily with visual indicators (e.g., smoke tubes, flutter strips), regardless of the presence of differential pressure sensing devices (e.g., manometers) [11, 12, 1023, 1024].
- V.D.2.a.iv. Keep the AIIR door closed when not required for entry and exit.

V.D.2.b. When an AIIR is not available, transfer the patient to a facility that has an available AIIR[12]. Category II

V.D.2.c. In the event of an outbreak or exposure involving large numbers of patients who require Airborne Precautions:

- Consult infection control professionals before patient placement to determine the safety of alternative room that do not meet engineering requirements for an AIIR.
- Place together (cohort) patients who are presumed to have the same infection (based on clinical presentation and diagnosis when known) in areas of the facility that are away from other patients, especially patients who are at increased risk for infection (e.g., immunocompromised patients).

Assessment of evidence

- Use temporary portable solutions (e.g., exhaust fan) to create a negative pressure environment in the converted area of the facility. Discharge air directly to the outside, away from people and air intakes, or direct all the air through HEPA filters before it is introduced to other air spaces[12] Category II

V.D.2.d. In ambulatory settings:

- V.D.2.d.i. Develop systems (e.g., triage, signage) to identify patients with known or suspected infections that require Airborne Precautions upon entry into ambulatory settings [9, 12, 34, 127, 134]. Category IA
- V.D.2.d.ii. Place the patient in an AIIR as soon as possible. If an AIIR is not available, place a surgical mask on the patient and place him/her in an examination room. Once the patient leaves, the room should remain vacant for the appropriate time, generally one hour, to allow for a full exchange of air [11, 12, 122]. Category IB/IC
- V.D.2.d.iii. Instruct patients with a known or suspected airborne infection to wear a surgical mask and observe Respiratory Hygiene/Cough Etiquette. Once in an AIIR, the mask may be removed; the mask should remain on if the patient is not in an AIIR [12, 107, 145, 899]. Category IB/IC.

VI.F.4. Implement Airborne Precautions for patients who require a Protective Environment room and who also have an airborne infectious disease (e.g., pulmonary or laryngeal tuberculosis, acute varicella-zoster). Category IA

- VI.F.4.a. Ensure that the Protective Environment is designed to maintain positive pressure[13]. Category IB
- VI.F.4.b. Use an anteroom to further support the appropriate air-balance relative to the corridor and the Protective Environment; provide independent exhaust of contaminated air to the outside or place a HEPA filter in the exhaust duct if the return air must be recirculated [13, 1041]. Category IB
- VI.F.4.c. If an anteroom is not available, place the patient in an AIIR and use portable, industrial-grade HEPA filters in the room to enhance filtration of spores [1042]. Category II

Assessment of evidence
In Table 4, the document states the following with regard to patient placement: “Prioritize for single-patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection” **Limitations** • Lack of detail provided to determine if a systematic literature review was carried out to obtain evidence. • May not be fully applicable to Scottish health and care settings

Evidence from previous update(s):

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Julian, S., Burnham, C. A. D., Sellenriek, P., Shannon, W. D., Hamvas, A., Tarr, P. I., & Warner, B. B. (2015). Impact of neonatal intensive care bed configuration on rates of late-onset bacterial sepsis and methicillin-	Retrospective cohort study	**Level 2+**	Placement in Single rooms	Placement in shared bays	Time to MRSA colonisation; Confirmed late-onset sepsis (CLOS) (defined as having a culture-positive pathogenic bacterial infection of the blood or CSF ≥72 hours of life for which the patient was treated with antibiotics for ≥5

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
resistant Staphylococcus aureus colonization. Infection control & hospital epidemiology, *36*(10), 1173-1182.					days; Combined CLOS and death.

Assessment of evidence

Objectives: To test the hypothesis that compared to infants in shared bays, infants in single-patient rooms have a lower risk of MRSA colonisation, late-onset sepsis and death.

Country: United States of America

Setting: Neonatal ICU in a Children's hospital

Background: The study was conducted in the NICU, which had 73 beds, 36 of which were single-patient rooms. The other beds were in three bays or open-unit areas, each with 9 or 14 beds. The same group of HCWs staffed both bed configurations. Patients were assigned to one of four multidisciplinary teams. Patient-to-nurse staffing ratios were 1-3:1, depending on illness severity. All patients were cared for using standard precautions, and infants colonised with MRSA were additionally subjected to contact isolation. Hand hygiene compliance was assessed and reported by the IPC team using direct observation during the study period.

Method: Data on patients who resided in the NICU from July 1, 2009, to November 30, 2011, were retrospectively obtained regardless of dates of admission or discharge. The data obtained included billing and coding data, infection control data, laboratory data, and data on daily patient room assignments, among others. At the time the data were collected, anterior nares

Assessment of evidence

swab specimens were used as part of routine infection control measures to screen for MRSA on admission and weekly thereafter. The first MRSA recovered from each patient was frozen for future analysis, including DNA extraction.

Three key outcomes were compared between patients in single-patient rooms and those in open units. The outcomes are time to MRSA colonisation, CLOS and combined CLOS or death. Kaplan-Meier curves and Cox regressions (including univariate, bivariate, and multivariate analyses) were used to determine the three outcomes. Patients who were transferred between the bed configurations were excluded from the study.

Results: A total of 1,823 subjects (55,166 patient days) were included in the analysis. Both groups were similar in terms of birth weight, sex, race, illness severity, and gestational age at birth. The median daily census was significantly higher in the single-patient rooms compared to the shared bays (32 vs 31; ANOVA, $p < 0.001$). The mean colonisation pressure (the ratio of MRSA-positive patient days to total patient days, expressed as a percentage). Hand hygiene compliance upon entry and exit of the room was similar across both bed configurations.

The incidence of MRSA colonisation was similar in single-patient rooms and shared bays (2.1% vs. 3.3%; χ^2 $p = 0.11$). No differences were observed over time, as demonstrated in the Kaplan-Meier plot provided. Univariate Cox regression showed no difference in MRSA colonisation rates between bed configurations ($\chi^2 = 0.1$), including when demographic, patient, and unit factors were controlled for.

The rates of CLOS were similar in single-patient rooms and shared bays (3.9% vs 4.1%; χ^2 $p = 0.89$), as was the combined outcome of CLOS or death (11.6% vs 10.8%; $p = 0.56$).

Limitation

- It is not clear how patients were initially allocated to the beds
- Transmission was not demonstrated
- The role of visitors to the wards was not considered as this could easily have been a source of infection; however, this is not likely to vary between the groups.

Assessment of evidence
Contribution to question: This study showed no difference in MRSA-related outcomes between neonatal patients placed in single rooms and those placed in open bays.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Ben-Abraham, R., Keller, N., Szold, O., Vardi, A., Weinberg, M., Barzilay, Z., & Paret, G. Do isolation rooms reduce the rate of nosocomial infections in the pediatric intensive care unit?. Journal of critical care, 2002:17(3), 176-180.	Before-and-after study	**Level 3**	Single patient rooms	N/A	Mean Nosocomial infections per child

Assessment of evidence
Objectives: This Israeli study compared the rate of Nosocomial infections (NIs) in the PICU before and after its conversion from an open-bay unit to separate single rooms.

Assessment of evidence

Country: Israel

Setting: Paediatric ICU

Method: The PICU in a 1,200-bed Israeli Medical Centre was transformed from an open-bay unit to a 6-bed single-room unit. Prospective surveillance of NI was conducted from May to October 1995, following the conversion, and compared to records of NI from the same period in 1992, before the transformation. The 1992 records were obtained via an examination of the medical records of all patients with NI who were admitted to the PICU. Other data collected included demographics, clinical information, diagnosis on admission, length of stay (LOS), presence of indwelling devices, staff numbers and seniority, antibiotic administration, and infection control policy.

An infection was identified as a nosocomial infection (NI) if it developed at least 48 hours after admission to the PICU. The surveillance focused on bacteraemia, pneumonia, and catheter-related infections, which were defined as a culture of catheter tips of at least 15 CFUs per plate. Bacteraemia was defined as the presence of at least one microorganism (except coagulase-negative Staphylococcus and Pseudomonas other than P. aeruginosa) isolated in a blood culture. Ventilator-associated pneumonia (VAP) was defined as one or more persistent new opacities associated with a positive bronchiolar lavage ($\geq 10^4$ CFU/ml), as shown on a radiograph. Positive pleural fluid or sputum cultures with the same organism isolated from blood cultures were considered diagnostic for pneumonia. “Catheter-related infection was defined by a positive catheter culture or systemic or local signs of infection that disappeared after catheter removal. Urinary tract infection was defined by the presence of 105 CFU/mL or greater in urine culture. Gastrointestinal infection refers to infection with bacterial pathogens such as Salmonella or Shigella or the presence of Clostridium difficile toxin in stools with gastrointestinal manifestations (ie, diarrhoea, vomiting, and nausea).”

The data were compared using parametric and non-parametric tests, including Student’s t-test, χ^2 test, and Fisher's exact test.

Results:

A total of 78 and 115 children were included in the study during the pre- (open bay) and post-periods (single rooms), respectively, being the patients who were admitted to the PICU for more than 48 hours. The senior medical and nursing staff were the same in

Assessment of evidence

both study periods. There were minor changes in junior staff but no changes in IPC protocols or barrier precautions. Glove use, aseptic techniques for invasive procedures, hand washing, and antibiotic use were "essentially the same."

The mean NI per child was significantly lower after transformation to single rooms than open bay units (1.87±0.2 vs 3.62±0.7; $p < 0.05$). The length of stay was also significantly lower during the single-room period (11±2 vs 25±6 days; $p<0.05$), as were the period prevalence of VAP (8% vs 22%; $p<0.05$) and UTI (3.2% vs 9%; $p<0.05$). Bacteraemia (7% vs 9%) and eye-related NIs (1.6% vs 3.0%) were also lower, but the decreases were not statistically significant. Candidemia (1.7% vs. 1.2%) and Git-related nosocomial infections (NIs) (13% vs. 12.8%) were higher during the single-room period; however, the difference was not statistically significant.

Limitations

- It is not clear if the children were tested or screened at admission or in regular intervals afterwards
- Although the same medical staff attended throughout the pre-and post-study periods, the experience level would have improved in the latter, being 3 years after the former.
- No formal evaluation of hand hygiene was conducted, despite the authors' report that the results were ‘essentially the same’.
- The mean age in the pre-period was reported as 53.3, but this has been considered a typo and is reported within this review as 5.3, as it was a paediatric ICU.
- It is unclear whether the shorter stay during the single-room period affected the rate of nosocomial infection or whether it resulted from the lower rate.
- The study was conducted between 1992-1995, and it is unclear how the practice has changed since then and what effect that has on the applicability of the findings in today’s ICU.

Assessment of evidence
Contribution to question This paper demonstrated a significant reduction in the mean number of nosocomial infections (NIs) per child. However, this should be interpreted with caution, considering the limitations and age of the paper.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Cepeda, J. A., Whitehouse, T., Cooper, B., Hails, J., Jones, K., Kwaku, F., ... & Wilson, A. P. R. Isolation of patients in single rooms or cohorts to reduce spread of MRSA in intensive-care units: prospective two centre study. The Lancet, 2005; 365(9456), 295-304.	Interrupted time series	**Level 3**	Isolation or cohorting (movement phase)	Patients left in beds where they were diagnosed with MRSA infection or colonisation (Non-movement phase)	Time to acquisition of MRSA from admission to ICU

Assessment of evidence

Objectives: This study aimed to assess the impact of isolation in single rooms or cohorts (alongside standard precautions) on MRSA transmission in intensive care units.

Country: UK

Setting: ICUs in two London teaching hospitals

Method: The study was conducted in three phases and included all patients admitted to the ICU for more than 48 hours. In the first (phase 1) and last three months (phase 3), patients found to be colonised or infected with MRSA were moved into single-room isolation or cohorted with other MRSA-positive patients (move phase). During the six-month period (phase 2), MRSA-positive patients were only moved into isolation or cohorting if they also had other multi-resistant or notifiable pathogens or required protective isolation (non-move phase). Existing MRSA patients were treated as new admissions at the end of each phase, i.e. moved to a bay or single room if in cohort isolation. Disposable aprons were worn by the nurses throughout the shift, and gloves were worn for all invasive procedures, washing or turning the patient, and contact with or disposal of body fluids of all the patients, whether MRSA-positive or not. Policies regarding hand hygiene, glove removal, and environmental cleaning remained the same throughout the study period. Nurses were cohorted for all patients with multi-resistant pathogens and for MRSA-positive patients during the move phase. Every bed space had allocated devices, such as stethoscopes, and ready access to a handwash sink, alcohol hand rub, and other items for hand hygiene.

Patients were screened within 24 hours of admission, every week thereafter, and at discharge, using samples collected from the nose or groin (or blood, wound, or sputum cultures when indicated). Incidence of MRSA infection and colonisation was thereafter calculated. Colonisation was defined as the presence of MRSA in the nose, groin, sputum or other sites but without requiring treatment with an antibiotic. Infection was defined as the presence of MRSA in a clinical site coinciding (within 5 days) with antimicrobial therapy. Every case in which MRSA infection was treated was assessed by a consultant. PFGE typed isolates of MRSA and MSSA are likely to represent new acquisitions.

The key outcome measure was the time to acquisition of MRSA from admission to the ICU. MRSA acquisition was defined as an MRSA-positive isolate taken after 48 hours of admission to ICU, provided the patient had no previous positive MRSA isolates documented and had at least one negative MRSA screen in the current episode. The timing was recorded to the nearest day,

Assessment of evidence

and patients were considered present in an area if they remained there for longer than 12 hours. Patients who did not acquire MRSA were considered censored at the time of the last screening sample. Analysis was done using the Cox proportional hazards model with the non-move intervention incorporated as a time-dependent covariate.

Results: Admission and discharge screening were successfully conducted in 80-87% and 71-75% respectively, in both hospitals over the three phases. The MRSA acquisition rate was similar in both the move and the non-move phases, with no change in prevalence or incidence. Both hospitals were able to isolate, or cohort colonised or infected patients throughout the move phase, even during periods of high MRSA prevalence.

“The crude (unadjusted) Cox proportional-hazards model showed no evidence of increased transmission during the non-move phase compared with the move phases. This finding was true both for the combined data stratified by hospital (hazard ratio 0·73 [95% CI 0·49–1·10], p=0·94 one-sided) and for hospitals A and B individually (0·72 [0·44–1·17], p=0·91 and 0·76 [0·37–1·58], p=0·77).”

Conclusion: The isolation or cohorting of MRSA patients in the ICU did not alter or improve the rate of MRSA transmission/acquisition.

Limitations

- No segmented regression analysis was done.
- Figures are quite unclear and challenging to make out.
- The counterfactual is not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Vonberg, R. P., Kuijper, E. J., Wilcox, M. H., Barbut, F., Tüll, P., Gastmeier, P., ... & Wiuff, C. (2008). Infection control measures to limit the spread of *Clostridium difficile*. Clinical Microbiology and Infection, 14, 2-20.	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: "This literature review and the recommendations contained in these guidelines were stimulated by the increased incidence of *C. difficile*-associated diarrhoea (CDAD) in multiple institutions and countries across Europe. Control measures for *C. difficile* differ in several important ways from those used to reduce the risk of other nosocomial pathogens. We recommend that this document be used to produce and/or review current local protocols for the control of nosocomial CDAD."

Country: Europe

The document provides the following recommendations on isolation precautions

Assessment of evidence
1. “Patients with CDAD represent a source for pathogen spread toothers and should be isolated in single rooms whenever possible. (IB) 2. A designated toilet or commode (transportable toilet) for CDAD patients should be provided. (IB) **Limitations** • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Sehulster, L., & Chinn, R. Y. W. Guidelines for Environmental Infection Control in Health-Care Facilities: Recommendations of the CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC).	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
2003 (updated July 2019) [Last accessed September 15, 2025)					

Assessment of evidence

Objectives: “The objective is to develop an environmental infection-control guideline that reviews and reaffirms strategies for the prevention of environmentally-mediated infections, particularly among health-care workers and immunocompromised patients. The recommendations are evidence-based whenever possible”

Country: USA

The document provides the following definitions:

Airborne infection isolation: “Airborne Infection Isolation (AII) refers to the isolation of patients infected with organisms spread via airborne droplet nuclei <5 µm in diameter. This isolation area receives numerous air changes per hour (ACH) (≥12 ACH for new construction as of 2001; ≥6 ACH for construction before 2001), and is under negative pressure, such that the direction of the airflow is from the outside adjacent space (e.g., corridor) into the room. The air in an AII room is preferably exhausted to the outside but may be recirculated provided that the return air is filtered through a high efficiency particulate air (HEPA) filter. The use of personal respiratory protection is al

“Protective Environment (PE) is a specialized patient-care area, usually in a hospital, with a positive airflow relative to the corridor (i.e., air flows from the room to the outside adjacent space). The combination of HEPA filtration, high numbers of air changes per hour (≥12 ACH), and minimal leakage of air into the room creates an environment that can safely accommodate patients who have undergone allogeneic hematopoietic stem cell transplant (HSCT)so indicated for persons entering these rooms.”

Assessment of evidence

The document provided the following relevant recommendations on air handling:

“D. Follow appropriate procedures for use of areas with through-the-wall ventilation units.120 Category IC (AIA: 8.31.D1, 8.31.D8, 9.31.D23, 10.31.D18, 11.31.D15)

1. Do not use such areas as PE rooms.120 Category IC (AIA: 7.2.D3)

2. Do not use a room with a through-the-wall ventilation unit as an AII room unless it can be demonstrated that all required AII engineering controls required are met.4, 120 Category IC (AIA: 7.2.C3)

E. Conduct an infection-control risk assessment (ICRA) and provide an adequate number of AII and PE rooms (if required) or other areas to meet the needs of the patient population. Category IA, IC (AIA: 7.2.C, 7.2.D)”

“G. Seal windows in buildings with centralized HVAC systems and especially with PE areas.35, 111, 120 Category IB, IC (AIA: 7.2.D3) ”

“H. Keep emergency doors and exits from PE rooms closed except during an emergency; equip emergency doors and exits with alarms. Category II”

The document also provided relevant recommendations on ‘infection control and ventilation requirements for PE Rooms’ (Note that the recommendations were minorly edited in 2017 to clarify meanings without changing their intent):

A. Minimize exposures of severely immunocompromised patients (e.g., solid organ transplant patients or allogeneic neutropenic patients) to activities that might cause aerosolization of fungal spores (e.g., vacuuming or disruption of ceiling tiles).9, 20, 109, 272 Category IB

B. Minimize the length of time that immunocompromised patients in PE are outside their rooms for diagnostic procedures and other activities.9, 283 Category IB

C. Provide respiratory protection for severely immunocompromised patients when they must leave PE for diagnostic studies and other activities; consult the most recent revision of CDC’s Guidelines for Prevention of Health-Care Associated Pneumonia for information regarding the appropriate type of respiratory protection.3, 9 Category II

Assessment of evidence

D. Incorporate ventilation engineering specifications and dust-controlling processes into the planning and construction of new PE units. Category IB, IC

1. Install central or point-of-use HEPA filters for supply (incoming) air.3, 18, 20, 44, 99–104, 120, 254, 316–318, 1432, 1434 Category IB, IC (AIA: 5.1, 5.2, 7.2.D)
2. Ensure that rooms are well sealed by • * properly constructing windows, doors, and intake and exhaust ports; • * maintaining ceilings that are smooth and free of fissures, open joints, and crevices; • * sealing walls above and below the ceiling, and * monitoring for leakage and making necessary repairs.3, 111, 120, 317, 318 Category IB, IC (AIA: 7.2.D3)
3. Ventilate the room to maintain ≥12 ACH.3, 9, 120, 241, 317, 318 Category IC (AIA: 7.2.D)
4. Locate air supply and exhaust grilles so that clean, filtered air enters from one side of the room, flows across the patient's bed, and exits from the opposite side of the room. 3, 120, 317, 318 Category IC (AIA: 7.31.D1)
5. Maintain positive room air pressure (≥2.5 Pa [0.01-inch water gauge]) in relation to the corridor.3, 35, 120, 317, 318 Category IB, IC (AIA: Table 7.2)
6. Maintain airflow patterns and monitor these on a daily basis by using permanently installed visual means of detecting airflow in new or renovated construction, or using other visual methods (e.g., flutter strips, or smoke tubes) in existing PE units. Document the monitoring results.120, 273 Category IC (AIA: 7.2.D6)
7. Install self-closing devices on all room exit doors in protective environments.120 Category IC (AIA: 7.2.D4)

E. Do not use laminar air flow systems in newly constructed PE rooms.316, 318 Category II

F. Take measures to protect immunocompromised patients who would benefit from a PE room and who also have an airborne infectious disease (e.g., acute VZV infection or tuberculosis).

8. Ensure that the patient's room is designed to maintain positive pressure. ~ Category IC

Assessment of evidence

9. Use an anteroom to ensure appropriate air balance relationships and provide independent exhaust of contaminated air to the outside, or place a HEPA filter in the exhaust duct if the return air must be recirculated.120, 317 Category IC (AIA: 7.2.D1, A7.2.D)

10. If an anteroom is not available, place the patient in AII and use portable, industrial-grade HEPA filters to enhance filtration of spores in the room.219 Category II

F. Maintain backup ventilation equipment (e.g., portable units for fans or filters) for emergency provision of ventilation requirements for PE areas and take immediate steps to restore the fixed ventilation system function.9, 120, 278 Category IC (AIA: 5.1)

The following recommendations of the document “Infection-Control and Ventilation Requirements for All Rooms” on were relevant to the review

“Implement environmental infection-control measures for persons with known or suspected airborne infectious diseases.

1. Use AII rooms for patients with or suspected of having an airborne infection who also require cough-inducing procedures, or use an enclosed booth that is engineered to provide

* ≥12 ACH;

• * air supply and exhaust rate sufficient to maintain a 2.5 Pa [0.01-inch water gauge] negative pressure difference with respect to all surrounding spaces with an exhaust rate of ≥50 ft3 /min.; and

• * air exhausted directly outside away from air intakes and traffic or exhausted after HEPA filtration prior to recirculation.4, 120, 348–350 Category IB, IC (AIA: 7.15.E, 7.31.D23, 9.10, Table 7.2)”

“2. Although airborne spread of viral hemorrhagic fever (VHF) has not been documented in a health-care setting, prudence dictates placing a VHF patient in an AII room, preferably with an anteroom to reduce the risk of occupational exposure to aerosolized infectious material in blood, vomitus, liquid stool, and respiratory secretions present in large amounts during the end stage of a patient’s illness.202–204

Assessment of evidence
• * If an anteroom is not available, use portable, industrial-grade HEPA filters in the patient's room to provide additional ACH equivalents for removing airborne particulates. • * Ensure that health-care workers wear face shields or goggles with appropriate respirators when entering the rooms of VHF patients with prominent cough, vomiting, diarrhea, or hemorrhage.203 Category II" (Note that recommendations in this guideline for Ebola has been superseded by other CDC documents). 3. Place smallpox patients in negative pressure rooms at the onset of their illness, preferably using a room with an anteroom if available.6 Category II D. No recommendation is offered regarding negative pressure or isolation rooms for patients with Pneumocystis carinii pneumonia.126, 131, 132 Unresolved issue

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health Facilities Scotland. Scottish Health Planning Note 04 In-patient Accommodation: Options for Choice Supplement 1: Isolation Facilities in Acute Settings.	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
September 2008 (Accessed: September 10, 2025).					

Assessment of evidence

Objectives: “This Supplement to SHPN 04: ‘In-patient accommodation: options for choice’, provides guidance on the facilities required for isolating patients on acute general wards.”

Country: Scotland

The document provides the following on ‘Isolation facilities’:

“In order to simplify the use of isolation facilities, this Supplement proposes two room designs for isolating patients in acute general settings:

- enhanced single room with en-suite facilities;
- enhanced single room with en-suite facilities and ventilated bed access lobby (isolation suite).

Enhanced single room with en-suite facilities

An enhanced single room with en-suite sanitary facilities having extract ventilation is a simple, cost-effective way to provide isolation, and will meet the needs of most patients on general wards. The room does not require any specialist knowledge or action by the nursing staff to operate it. When not being used for isolation the room can be used for general nursing.

Enhanced single room with en-suite facilities and ventilated lobby (isolation suite)

An enhanced single room with a positive pressure ventilated bed access lobby and en-suite facilities with extract ventilation provides both source and protective isolation. The positive pressure lobby ensures that air from the corridor does not enter the isolation room, and that air from the room does not escape into the corridor. This simple design enables the suite to be used for

Assessment of evidence
both source and protective isolation without the need for switchable ventilation or special training for staff. It also provides safe isolation for patients whose exact condition is unknown. Advantages Both rooms are suitable for caring for patients not in isolation but who require a single room for other reasons. In addition, both room designs are simple in concept, by default safe in operation, and do not require the nursing staff to have any specialist ventilation knowledge." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health Information and Quality Authority. National Standards for the prevention and control of healthcare-associated infections in acute	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
healthcare services. May 23, 2017 (Last accessed: 28/08/2025).					

Assessment of evidence

Objectives: “The revised National Standards are designed to promote a safe and effective infection prevention and control environment within acute healthcare services.”

Country: Republic of Ireland

Under Standard 2.5: “Service providers identify and manage a patient’s infection prevention and control healthcare needs in a timely and effective manner”, the document states the following as one of the features that shows that a service is meeting the standard:

“Arrangements are in place to facilitate isolation of patients with suspected or confirmed communicable disease, including healthcare-associated infection and colonisation with a multidrug-resistant micro-organism. This includes appropriate placement in a suitable and clearly identifiable isolation room, single room or cohort area, in line with best practice. The expertise of the infection prevention and control team is sought regarding isolation prioritisation whenever suitable rooms are not readily available.”

Under Standard 2.7: “Equipment is cleaned and maintained to minimise the risk of transmitting a healthcare-associated infection”, the following was listed as a feature that a service is meeting the standard:

“Dedicated equipment in rooms designated for isolation is appropriately decontaminated prior to use on another patient.”

The document provides the following definitions in the glossary:

Assessment of evidence

- "Isolation: physically separating patients to prevent the spread of infection."
- "Isolation room: an enhanced single room with en-suite facilities and ventilated lobby. The pressure in the room is dependent on whether the patient needs source isolation (for infections spread by airborne route such as influenza or TB) or protective isolation (for the care of immunocompromised patients)."
- "Single room: a patient bedroom which accommodates one patient only. Single rooms should also have en-suite facilities. Isolation in a single room is effective in reducing transmission of infections spread by the contact or droplet routes, when combined with other infection prevention and control measures such as hand hygiene and personal protective equipment."

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Question 3: What is a cohort area, and when should patients or residents be placed in these areas?

Evidence added to Literature Review V3.0:

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Carrara E, Ong DS, Hussein K, Keske S, Johansson AF, Presterl E, Tsioutis C, Tschudin-Sutter S, Tacconelli E. ESCMID guidelines on testing for SARS-CoV-2 in asymptomatic individuals to prevent transmission in the health care setting. Clinical Microbiology and Infection. 2022 May 1;28(5):672-80.	Guideline	**AGREE Recommend with modifications**	N/A	N/A	N/A

Assessment of evidence
Objectives: This European "guideline addresses the indications for direct testing of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in asymptomatic individuals in health care facilities, with the aim to prevent SARS-CoV-2 transmissions in these settings." The guidance makes the following recommendations with regards to asymptomatic testing: • "The panel suggests monitoring for the development of symptoms among low-risk exposure contacts, although if the hospitalized patient population is vulnerable or transmission is likely, testing is recommended (strong recommendation, QoE: very low); if low-risk exposure occurs, patients can be cohorted in the same room or discharged when possible (good practice recommendation)" **Limitations** • No external review by experts before publication • Opinion of patients (or public) not sought – this may be offset by the severity of the situation, i.e a global pandemic. • The search criteria and search strategy are not provided. • The strengths and limitations of the systematic reviews included in the guidelines are not stated. Although AMSTAR ratings are provided for each, it is unclear what strengths or limitations informed the rating. It should also be stated that no systematic reviews were identified for the recommendations relevant to the present review, and the recommendations are based on expert opinion and other level 4 documents.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organization. Clinical management of COVID-19. Living guideline. 13 January 2023 (Last accessed: 20/08/20205).	Guideline	**AGREE Recommend with modifications**	N/A	N/A	N/A

Assessment of evidence

Objectives: “This guideline aims to be trustworthy and living; dynamically updated and globally disseminated once new evidence warrants a change in recommendations for COVID-19.”

The document provides the following strong recommendations with regards to isolation:

“Isolate and cohort patients with suspected or confirmed COVID-19

- Where possible, designate a team of health workers to care for patients with suspected or confirmed COVID-19 and restrict their contact with COVID-19 patients.
- Place all cases in well ventilated single rooms if feasible. When single rooms are not available or bed occupancy rate is anticipated to be 100% or more, suspected, probable or confirmed COVID-19 patients should be grouped together (cohorted) in adequately ventilated areas with bed space at least 1 m apart.”

Assessment of evidence
Limitations (and other relevant points) • The evidence underlying the recommendations of interest is also unclear as it has not been directly linked to the recommendations within the document. • The document notes that the WHO commissioned an independent systematic review by the University of British Colombia to consider questions relevant to the present review, but it is not clear how these have been used in the formulation of the recommendations or how the review itself was conducted as the methods are not provided. • This document has been graded 'Recommend with modifications' because, despite the limitations highlighted, it reflects an up-to-date guideline on a pandemic with many uncertainties – which should be considered when it is used to inform recommendations or good practice points. • It should also be noted that this was not the most recent guidance update as of the time of writing. However, it was published on 13 January 2024 and provides the evidence synthesis for the recommendations of interest, which have remained unchanged in the most recent update published on 18 August 2024.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organization. Clinical management and infection prevention and control of mpox: living guideline.	Guideline	**AGREE 'Recommend with modifications'**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
May 2025 (Last accessed 28/08/2025)					

Assessment of evidence

Objectives: “This document is for public health specialists, health emergency responders, clinicians, health facility managers, health and care workers and IPC practitioners including but not limited to those working in primary care clinics, sexual health clinics, emergency departments, dental practices, infectious diseases clinics, genitourinary clinics, maternity services, paediatrics, obstetrics and gynaecology and acute care facilities that provide care for patients with suspected or confirmed mpox.”

On Patient placement

“Place patients on contact and droplet precautions for mpox in a single room.

- If a single room is not available or single rooms are limited:
  - ✓ Patients suspected to have mpox and patients deemed as probable mpox cases should be prioritized for a single rooms;
  - ✓ Consider cohorting patients who are confirmed to have mpox.
- Physically separate patients by at least 1 metre (3 feet) and draw privacy curtains.
- Whenever others are in the room and if transport is necessary:
  - ✓ clothing and/or sheet that comfortably covers the lesions.
  - ✓ The patient should wear a wear a medical mask (if able and tolerates) and follow respiratory hygiene and cough etiquette.”

Assessment of evidence

"WHO recommends, at the first point of contact with the health system, screening and triage should be performed for all persons who present with a rash and fever and/or lymphadenopathy, according to locally adapted WHO case definition, to identify individuals with suspected or confirmed mpox infection.

- Persons with symptoms that meet the case definition for suspected mpox [108] (see Annex 1: WHO case definitions for mpox outbreak in non-endemic countries) should enter the mpox clinical care pathway and immediately be given a well-fitting medical mask and isolated in a well-ventilated single room. If a well-ventilated single room is not available, then group patients with similar clinical diagnosis and based on epidemiological risk factors, with a spatial separation (at least 1 metre between patients).
- Suspected cases should not be cohorted together with confirmed cases"

"In patients with suspected or confirmed mpox, WHO suggests that health and care workers use contact and droplet precautions.*

- Consider using a respirator when the ventilation is poor or unknown or based upon a risk assessment (e.g. immunocompromised status or presence of mucosal lesions).
- Airborne precautions should be implemented if varicella zoster virus (i.e. chickenpox) or measles are suspected and until they are excluded.
- Airborne precautions should be implemented when performing aerosol-generating procedures (AGPs).
- If single rooms are not available or in limited supply, cohort confirmed patients and prioritize single rooms for suspect and probable patients."

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Coia JE, Wilson JA, Bak A, Marsden GL, Shimonovich M, Loveday HP, Humphreys H, Wigglesworth N, Demirjian A, Brooks J, Butcher L. Joint Healthcare Infection Society (HIS) and Infection Prevention Society (IPS) guidelines for the prevention and control of meticillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities.	Guidelines	**AGREE Recommend with modifications**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Journal of Hospital Infection. 2021 Dec 1;118:S1-39.					

Assessment of evidence

Objectives: "The main scope of the guidelines is to provide advice for the optimal provision of an effective and safe healthcare service while reducing the risk of MRSA transmission in healthcare settings. The guidelines are suitable for patients of all age groups. These guidelines were largely developed with hospitals in mind but may be useful in other settings where MRSA is a concern, for example long-stay units. The guidelines' main focus was the prevention of transmission to patients, thus pre and perioperative care was not included."

Country: United Kingdom

"GPP 11.3 When considering the need to isolate a patient with MRSA in a single room, other demands on single-room use may take priority and alternative strategies such as nurse cohorting may be appropriate."

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
MacCannell T, Umscheid CA, Agarwal RK, Lee I, Kuntz G, Stevenson KB, Healthcare Infection Control	Guideline	**AGREE Recommend with modifications**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Practices Advisory Committee. Guideline for the prevention and control of norovirus gastroenteritis outbreaks in healthcare settings. Infection Control & Hospital Epidemiology. 2011 Oct;32(10):939-69. Last updated February 15, 2017 (Last accessed: 20/08/2025).					

Assessment of evidence

Objectives: “This guideline addresses prevention and control of norovirus gastroenteritis outbreaks in healthcare settings. The guideline also includes specific recommendations for implementation, performance measurement, and surveillance.”

The document provides the following:

- “…When patients with norovirus gastroenteritis cannot be accommodated in single occupancy rooms, efforts should be made to separate them from asymptomatic patients. Dependent upon facility characteristics, approaches for cohorting

Assessment of evidence

patients during outbreaks may include placing patients in multi-occupancy rooms, or designating patient care areas or contiguous sections within a facility for patient cohorts. (Category IB) (Key Question 3C.4.b)

- …Consider longer periods of isolation or cohorting precautions for complex medical patients (e.g., those with cardiovascular, autoimmune, immunosuppressive, or renal disorders) as they can experience protracted episodes of diarrhea and prolonged viral shedding. Patients with these or other comorbidities have the potential to relapse, and facilities may choose longer periods of isolation based on clinical judgment. (Category II) (Key Question I.A.2.a)
- Consider extending the duration of isolation or cohorting precautions for outbreaks among infants and young children (e.g., under 2 years), even after resolution of symptoms, as there is a potential for prolonged viral shedding and environmental contamination. Among infants, there is evidence to consider extending contact precautions for up to 5 days after the resolution of symptoms. (Category II) (Key Question 3.A.1)"

Limitations

- Most of the underpinning evidence for recommendations related to this review was considered low quality.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency of Canada. Infection prevention and control for COVID-19: Interim	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
guidance for long-term care homes. June 16, 2021. (Last accessed: 20/08/2025)					

Assessment of evidence

Objectives: “PHAC is updating its interim guidance on infection prevention and control in long term-care homes (LTCHs) to consider emerging data on the transmission of SARS-CoV-2, the virus that causes COVID-19.”

Country: Canada

On Resident Placement

- “Cohorting residents who are confirmed to have COVID-19 in the same room should only be considered when other options are not available, and in consultation with IPC experts. Factors to consider when making decisions about cohorting within a room include:
  - ✓ Availability of single rooms and prioritization based on likelihood of transmission and associated morbidity with COVID-19 and colonization and/or infection with other pathogens that require resident isolation
  - ✓ For SARS-CoV-2, some considerations (where information is available) include: individual and/or community variant risk, status or prevalence, up-to-date information on variant potential for immune-escape, reinfection or superinfection, and time from onset of infection
  - ✓ Anticipated requirement for procedures or situations that may increase risk of pathogen transmission”

Limitations

- Method of producing guidance not stated.

Assessment of evidence
• Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
NHS England. Guidance for risk assessment and infection prevention and control measures for measles in healthcare settings.v1.1 24 January 2024 (Last accessed: August 20, 2025).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence
Objectives: "This guidance is intended to support preparedness for and management of suspected or confirmed measles cases in healthcare settings. It sets out key infection prevention and control (IPC) principles required to prevent transmission of measles in healthcare settings and provides resources to support patient screening, triage, management and assessment of risk applying the hierarchy of controls." Country: England The document provides the following on patient placement:

Assessment of evidence

"2.2.3. Patient placement and cohorting in inpatient settings

In the hospital setting, patients with suspected or confirmed measles should, whenever possible, be placed in a negative-pressure isolation room with en-suite facilities.

If negative-pressure isolation rooms are limited, infectious patients who have conditions that could increase the risk of transmission of infection to other patients (such as an excessive cough) should be prioritised for placement in a single room, ideally with en-suite facilities. Patients should be moved to a negative-pressure isolation room as soon as one becomes available. If a single room or a negative-pressure isolation room is not available, cohort patients with confirmed measles with other patients confirmed to have the same infectious agent.

In a situation where multiple suspected and confirmed measles cases occur (for example, during an outbreak) patients with suspected infection can be cohorted together following a risk assessment. However, they should not be cohorted with confirmed measles cases. Risk assessment should consider the vaccination and disease history of suspected cases and individuals who may be exposed.

Infectious patients should only be transferred to other departments if clinically necessary."

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. *Candidozyma auris*: guidance for acute healthcare settings. August 21, 2025. (Last accessed: September 10, 2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: "It is designed to support the adoption and implementation of the main guidance within acute healthcare settings. This document should be used in conjunction with the main guidance, which provides the supporting evidence and rationale underpinning these recommendations."

Country: England (Guidance has been agreed for use in Scotland by the SHPN "through the agreed review and adoption process" (see Guide for use in Scotland - Public Health Scotland).

The document provides the following on patient placement:

- "Isolate or cohort patients colonised or infected with C. auris."

Limitations

- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. Management of acute respiratory infection outbreaks in care homes guidance. July 24, 2024 (accessed August 19, 2025).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

"This guidance provides information and advice for health protection practitioners and community infection prevention and control professionals, based in local authorities or in the NHS who have similar responsibilities, and for HPTs in the devolved administrations; when requested to advise on the management of suspected viral ARI outbreaks in Care Quality Commission (https://www.cqc.org.uk/) (CQC) registered care homes for adults in England."

On Isolation

"It is recognised that care homes are residential settings and that cohorting approaches (keeping cases together) is likely to be impractical in terms of moving people from their usual room of residence. This may particularly be the case where there are high numbers of people with dementia. For larger homes it is reasonable to attempt to restrict movement between areas (such as floors or units) so that cases in one area are not able to seed infection to another area, including through fomites such as surfaces and items in communal areas.

Assessment of evidence
Within an area of the home that has cases, efforts should be made to prevent infection of other residents. In such areas there may be infected residents who are not yet symptomatic but may be or become an infection risk to un-infected residents." "Care home residents admitted to hospital with a diagnosis of influenza, or other respiratory viral infections may remain infectious to others even after discharge from hospital, and IPC measures as outlined in this guidance are indicated to prevent transmission to others. Residents may be discharged from hospital at any point when the following criteria are satisfied. • …Appropriate IPC measures to prevent transmission of infection, including single room dwelling or cohorting, will be continued outside hospital until a minimum of 5 days after the onset of symptoms. Note that in some circumstances (see above) it may be considered necessary to continue infection control measures beyond these periods." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
European Centre for Disease Prevention and Control. Considerations for infection prevention and control practices in relation to respiratory viral	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
infections in healthcare settings. February 6, 2023 (accessed August 19, 2025).					

Assessment of evidence

Objectives: This European document "aims to support the development of guidance for healthcare facilities and healthcare providers in the European Union/European Economic Area (EU/EEA) on infection prevention and control (IPC) measures for the management of patients with respiratory tract viral infection in healthcare settings."

Country: EU/EEA

The document notes the following on patient placement:

"Ideally, patients with confirmed respiratory viral infection, or probable respiratory viral infection with confirmatory test results pending, should be placed in a single room. If the number of cases exceeds the single-room capacity, patients with the same viral infection can be placed in the same room (cohorting). Patients with co-infections involving two (or more) respiratory viruses, immunocompromised patients, patients with pronounced symptoms and those requiring bedside procedures associated with a high risk of transmission should be prioritised for placement in single rooms."

In-patient Care

- "If the number of patients with respiratory viral infections exceed the single-room capacity of the hospital/facility/ward, patients with the same viral infection can be placed in the same room (cohorting). Patients with co-infections involving two (or more) respiratory viruses, immunocompromised patients, patients with pronounced symptoms and those requiring bedside procedures associated with high risk of transmission should be prioritised for placement in single rooms.

Assessment of evidence
Cohorting of patients with suspected respiratory viral infection awaiting diagnostic confirmation alongside other patients with confirmed or suspected infection should be avoided." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organization. Infection Prevention and control in the context of COVID-19: a guideline. 21 December 2023 (Last accessed: 20/08/20205).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence
Objectives: "The objective of this technical guideline is to provide the most up-to-date recommendations for IPC measures to be implemented when caring for people with or managing outbreaks of COVID-19."

Assessment of evidence

Evidence level: This document was graded SIGN50 level 4 because despite describing a good methodology, the evidence underpinning it was gathered using a rapid review. It was not clear which part of the methodology was streamlined or accelerated.

The document provides the following on placement of patients with suspected or confirmed COVID-19:

- "Isolation is used to separate people with confirmed or suspected COVID-19 from those without COVID-19.
  - A patient with suspected or confirmed COVID-19 should be cared for in a separate, well-ventilated area, preferably in an isolation room or single-patient room, if available.
  - WHO recommendations for the duration of isolation can be found here [52].
- Maintain a physical distance of at least 1 metre between patients, increasing that distance where possible.
- When making decisions about patient placement, health and care workers may consider factors such as the availability of single rooms, and anticipated requirements for procedures or situations that may increase the risk and/or likelihood of transmission.
- Cohorting patients confirmed to have COVID-19 in the same room is a consideration when other options are not available. Patients should stay in their rooms, with restrictions to movement or transport to essential activities."

Limitations

- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organization. Transmission-based precautions for the prevention and control of infections – Aide-memoire. 20 June 2022 (Last accessed: 20/08/20205).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

"Transmission-based precautions are used in addition to standard precautions for patients with known or suspected infection or colonization with transmissible and/or epidemiologically significant pathogens. The type of transmission-based precautions assigned to a patient depends on the transmission route of the microorganism: contact, droplet, or airborne."

"Cohorting

Cohort patients – place patients with similar symptoms and diagnosis in one area to confine their care and prevent contact with other patients."

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health New Zealand. COVID-19 infection prevention and control guidance for acute care hospitals. March 2024. (Last accessed: August 18, 2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: "This guidance is applicable to all district hospitals that are receiving, assessing, and caring for patients suspected or confirmed to have COVID-19 infection or patients who during risk assessment are identified as being at high risk of COVID-19 infection and outlines the infection prevention and control (IPC) measures to provide a safe workplace for people, patients, and staff in acute care hospitals."

Country: New Zealand.

On Patient Cohorting

"Cohorting refers to the co-location of patients with the same characteristic, in this case the same infectious disease. It may be in a multi-bedded room, part of a ward or an entire ward. If a cohort zone for COVID-19 patients is used, this must have physical separation including air handling from non-COVID treatment zones. The COVID-19 cohort zone must have own entry and exit, not be a thoroughfare to other clinical areas, must have necessary equipment located within unit, and ideally should not be located adjacent to wards containing vulnerable patient populations. IPC team should be involved in implementation of COVID-19

Assessment of evidence
cohort zone to ensure appropriate risk mitigation processes are in place. Consider use of portable air handling units to enhance ventilation in shared spaces. Depending in capacity, consider reducing patient density in cohort areas (e.g. only fill every second bed). Processes for PPE use, cleaning and management of emergencies should be in place for COVID-19 cohort areas. It is advised not to place suspected COVID-19 patients (those pending test results or those on symptom watch following an exposure event) in a cohort zone. MDTs and other meetings should not occur in a COVID-19 cohort zone." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health New Zealand. New Zealand Vancomycin resistant Enterococci (VRE) infection prevention and control guidelines.	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
April 24, 2024 (Last accessed: 20/08/2025)					

Assessment of evidence

Objectives: "This guidance document has been developed by the VRE Infection Prevention and Control Technical Advisory Group using international guidance and resources to enable healthcare facilities develop their own policies and procedures based on their environment when providing patient care."

Country: New Zealand

On Room placement

"If VRE identified from screening or from a clinical sample, or if admitting patient with known colonisation or infection with VRE, the following measures are recommended:

- …Room placement: single room with own toilet facilities is recommended.
  - ✓ A dedicated commode can be used for the duration of the patient's hospital stay if no en-suite toilet. Commode to be kept in patient's room.
  - ✓ Toilet facilities must not be shared with any patient who does not have VRE.
  - ✓ if no single rooms available, cohort with another patient with VRE is acceptable.
  - ✓ Cohorting with patients with other MDROs (especially MRSA) is not acceptable.
  - ✓ If single rooms are limited prioritise those patients who have risk factors for transmission e.g. diarrhoea or uncontained faecal continence, urinary incontinence, discharging wounds that a dressing cannot contain."

Additional core measures for facilities with recent or ongoing VRE outbreak/cluster

Assessment of evidence

- "Implementation of transmission based precautions/room placement: Place VRE cases under contact precautions. Implement cohorting if needed. o Place VRE contacts under pre-emptive contact precautions. Do not cohort with confirmed VRE cases while contact undergoing screening. May be cohorted with other VRE contacts.
  - ✓ Avoid sharing of toilet facilities with any other patients
  - ✓ If not already, consider using disposable antimicrobial curtains."

On management of a resident with VRE in Aged and Residential Care Facilities

"Residents with VRE should be placed in a single room with an ensuite.

When a single room with an ensuite is not available or sharing a room is unavoidable following a risk assessment consider alternative ways to reduce the risk of transmission, for example,

- …
- If single room is not possible cohort residents with the same strain of VRE in the same room.
- If cohorting is not possible place in room with resident considered to be low risk (i.e. not immunocompromised, without open wounds, drains or indwelling medical devices)
- When sharing a room is required consider the resident with VRE has dedicated bathroom. The bathroom should be cleaned after use or a dedicated commode can be used, with controls in place for emptying and cleaning that avoids environmental contamination."

Limitations

- Method of producing guidance not stated.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency. Update COVID-19 Testing Arrangements in Care Homes and Hospices. February 29, 2024. (Last accessed September 11, 2025)	Guidance (Letter to Residential Care Home and Nursing Home Managers and Hospice Directors)	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Country: Northern Ireland

On Cohorting (as part of outbreak management)

- "Where there are shared bedrooms or bathrooms and/or multiple cases, cohorting (grouping) of residents/patients into those affected and those unaffected should be considered. Grouping residents/patients may make care easier and may reduce the risk of spread to unaffected residents/patients.
- If cohorting of staff, residents/patients and equipment is not possible, perform all tasks e.g. care rounds, in following order:
    i. Unaffected residents/patients
    ii. Resident/patient contacts
    iii. Symptomatic residents/patients

Assessment of evidence
iv. Confirmed residents/patients." **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. Framework of actions to contain carbapenemase-producing Enterobacterales. September 2022 (Last accessed: 20/08/20205)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This framework aims to provide health and social care organisations with a useful and pragmatic set of actions to support the implementation and monitoring of interventions to prevent and control the spread of CPE." Country: UK					

Assessment of evidence

On Cohorting the document provides the following:

- “In acute care facilities all inpatients screened for or known to be CPE positive should be managed in a single room with en-suite facilities, where possible.
- If isolation is not possible, patients with the same carbapenemase enzyme and organism can be cohorted within one ward (or defined area of a ward).”

“Cohorting for CPE is recommended as a second line if isolation is not feasible. This should be considered as a pragmatic alternative to isolation when there is an increase in the number of patients with CPE in a defined clinical area or speciality, on the advice on infection control specialists.

Patients with same acquired carbapenemase enzyme and organism can be cohorted within one ward (or defined area of a ward) with dedicated bathroom facilities, equipment and staffing. Patients or residents with different mechanisms of resistance should not be cohorted together.

The following need to be assessed when agreeing cohorting arrangements:

- duration of length of stay of patients and clinical need
- enhanced IPC support for staff including education, training and monitoring of compliance with contact precautions
- increased environmental cleaning of the cohort area
- ability to provide a dedicated cohort of nursing staff over 24 hours
- geographical location of cohort area including dedicated toilet or bathroom facilities
- provision of dedicated patient-shared equipment (disposable where possible)
- if the cohort area is part of a ward (rather than the whole ward), consider CPE screening of patients in other parts of the same ward as an indication of onward transmission

Assessment of evidence

- impact on patient flow across the wider organisation”

“In outpatient settings and ambulatory care settings, faecally continent patients with CPE who have no other risk factors, present a very low risk of transmission and therefore isolation or cohorting are not routinely required. However, where feasible their close contacts should have their records flagged for admission CPE screening to acute care hospitals. In contrast, CPE colonised patients with diarrhoea pose a greater risk of transmission and, environmental and equipment decontamination will be required following their visit.”

“Where possible, specimens that undergo one-step detection should also be cultured; CPE negative isolates may require further characterisation to determine whether referral to AMRHAI is warranted to screen for rarer carbapenemases, whilst CPE positive specimens may require culture for organism identification, typing and determination of the antibiogram, particularly in situations where patient cohorting is being considered.”

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Center for Disease Control and Prevention. Implementation of Personal Protective Equipment (PPE) Use in Nursing	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) July 12, 2022 (Last accessed September 09, 2025)					

Assessment of evidence

Objectives: This American document is “intended to provide guidance for PPE use and room restriction in nursing homes for preventing transmission of MDROs, including as part of a public health response”.

Country: USA

Under contact precaution for MDRO prevention, the document states the following:

“Contact Precautions require the use of gown and gloves on every entry into a resident’s room. The resident is given dedicated equipment (e.g., stethoscope and blood pressure cuff) and is placed into a private room. When private rooms are not available, some residents (e.g., residents with the same pathogen) may be cohorted, or grouped together. Residents on Contact Precautions should be restricted to their rooms except for medically necessary care and restricted from participation in group activities.

Because Contact Precautions require room restriction, they are generally intended to be time limited and, when implemented, should include a plan for discontinuation or de-escalation.”

The document also makes the following distinctions between enhanced barrier precautions and contact precautions:

Assessment of evidence
"…Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk." **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Center for Disease Control and Prevention. Infection Control Guidance: *Candida auris.* April 24, 2024.	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: This American guidance provides recommendations for infection control of Candida auris in health and care settings. Country: USA The document provides the following 'Considerations for patient room placement' in 'Hospitals and nursing homes':					

Assessment of evidence

"…Facilities can group *C. auris* patients together in a dedicated unit or part of a unit. This decreases movement of healthcare personnel and equipment to non-affected areas. Facilities could also consider dedicating healthcare personnel (e.g., nurses, nursing assistants) who provide regular care to these patients during a shift.

In nursing homes, facilities with the capacity may consider placing patients with *C. auris* in single-patient rooms. Healthcare providers can find recommendations about patient placement in nursing homes using Enhanced Barrier Precautions (EBP) in CDC's FAQs about Enhanced Barrier Precautions in Nursing Homes.

When single rooms are not available, facilities may choose to cohort patients with *C. auris* together in the same room. It is preferable to cohort patients with the same MDROs together. However, facilities may assign rooms based on single (or a limited number of) high-concern MDROs (e.g., *C. auris* or carbapenemase-producing Enterobacterales) without regard to co-colonizing organisms."

The document also provides the following comments on the benefits and drawbacks to patient cohorting

"Before making decisions to cohort patients according to *C. auris* or other high-concern MDROs, consider the benefits and drawbacks. Ensure these practices are implemented without increasing the risk of pathogen spread in dedicated units or areas in a facility.

Benefits

Placing patients with *C. auris* or other high-concern MDROs in the same room, or in a dedicated unit, wing, or area (even if in single-patient rooms) with dedicated staff can help prevent the transfer of healthcare personnel and equipment between those colonized or infected with *C. auris* and those who are not.

This strategy may be best used for initial room assignments in facilities performing admission screening for select MDROs or for a single MDRO in facilities with an acute outbreak.

Assessment of evidence
Drawbacks Moving patients to the same room, unit, or areas based on MDROs increases patient movement, and in some circumstances, increases *C. auris* transmission. This risk increases if there are gaps in environmental cleaning. Facilities choosing to implement this strategy should do so in a way that reduces overall exposures throughout the facility. This includes avoiding frequent room changes that lead to environmental contamination in more areas and more healthcare contacts that could be exposed." **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
US Centers for Disease Control and Prevention (CDC). Infection Control Guidance: SARS-CoV-2. June 24, 2024 (Accessed 19 August, 2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: This American guidance "provides a framework for facilities to implement select infection prevention and control practices (e.g., universal source control) based on their individual circumstances (e.g., levels of respiratory virus transmission in the community)."

Country: USA

The document provided the following provisions for specific settings:

"In addition to the recommendations described in the guidance above, here are additional considerations for the settings listed below.

Dialysis Facilities

Considerations for Patient Placement

- Patients on dialysis with suspected or confirmed SARS-CoV-2 infection or who have reported close contact should be dialyzed in a separate room with the door closed. Hepatitis B isolation rooms can be used if: 1) the patient is hepatitis B surface antigen-positive or 2) the facility has no patients on the census with hepatitis B infection who would require treatment in the isolation room.
- If a separate room is not available, patients with confirmed SARS-CoV-2 infection should be cohorted to a specific well-ventilated unit or shift (e.g., consider the last shift of the day). Only patients with confirmed SARS-CoV-2 infection should be cohorted together."

Limitations

- Method of producing guidance not stated.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for Isolation precautions: Preventing Transmission of Infectious Agents in Health Care Settings. Last updated July 2023.	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: This American guideline aims to provide infection control recommendations for all components of healthcare, reaffirm standard precautions as foundation for preventing transmission during patient care, and reaffirm the importance of transmission-based precautions. Country: United States of America					

Assessment of evidence

The document states the following on patient placement:
"V.B.2. Patient placement

… When single-patient rooms are in short supply, apply the following principles for making decisions on patient placement:

- V.B.2.a.i. Prioritize patients with conditions that may facilitate transmission (e.g., uncontained drainage, stool incontinence) for single-patient room placement. Category II
- V.B.2.a.ii. Place together in the same room (cohort) patients who are infected or colonized with the same pathogen and are suitable roommates [29, 638, 808, 811-813, 815, 818, 819] Category IB

If it becomes necessary to place a patient who requires Contact Precautions in a room with a patient who is not infected or colonized with the same infectious agent:

- V.B.2.a.iii. Avoid placing patients on Contact Precautions in the same room with patients who have conditions that may increase the risk of adverse outcome from infection or that may facilitate transmission (e.g., those who are immunocompromised, have open wounds, or have anticipated prolonged lengths of stay). Category II
- V.B.2.a.iv. Ensure that patients are physically separated (i.e., >3 feet apart) from each other. Draw the privacy curtain between beds to minimize opportunities for direct contact.) Category II"

"V.C.1. Patient placement

- V.C.1.a. In acute care hospitals, place patients who require Droplet Precautions in a single-patient room when available Category II When single-patient rooms are in short supply, apply the following principles for making decisions on patient placement:
- V.C.2.a.i. Prioritize patients who have excessive cough and sputum production for single-patient room placement Category II

Assessment of evidence

- V.C.2.a.ii. Place together in the same room (cohort) patients who are infected the same pathogen and are suitable roommates [814,816]. Category IB If it becomes necessary to place patients who require Droplet Precautions in a room with a patient who does not have the same infection:
- V.C.2.a.iii. Avoid placing patients on Droplet Precautions in the same room with patients who have conditions that may increase the risk of adverse outcome from infection or that may facilitate transmission (e.g., those who are immunocompromised, have or have anticipated prolonged lengths of stay). Category II
- V.C.2.a.iv. Ensure that patients are physically separated (i.e., >3 feet apart) from each other. Draw the privacy curtain between beds to minimize opportunities for close contact103, 104 410. Category IB”

Limitations

- Lack of detail provided to determine if a systematic literature review was carried out to obtain evidence.
- May not be fully applicable to Scottish health and care settings.

Evidence from previous update(s):

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
García-Lecona, D. A., Garza-González, E., Padilla-Orozco, M., Mendoza-Flores, L., Flores-Treviño, S., Mendoza-Olazaran, S., & Camacho-Ortiz, A. Outcomes of *Clostridium difficile*–infected patients managed in a common isolation unit compared with isolation in their bed of diagnosis. American journal of infection control, 2017; 46(1), 103-104.	Retrospective chart review	**Level 3**	Patients admitted to a common isolation unit (CIU) following CDI diagnosis	Patients who remained in their original beds (OB) after CDI diagnosis	Recurrence of CDI 39-day mortality

Assessment of evidence

Objectives: This study aimed to compare the clinical variables and outcomes of CDI patients admitted to a common isolation unit (CIU) with those who remained in their original bed (OB), where they were placed under isolation precautions.

Country: Mexico

Background: The study was conducted in a 500-bed University hospital in Mexico, which has shared rooms with multiple beds (2-8) and a small proportion of single rooms (<10%). One of the shared rooms with four beds was designated a common isolation unit (CIU) for CDI patients. The CIU was staffed with 1-2 nurses and one medical attendant per shift. Patients diagnosed with CDI during the study period (January 2014 – December 2016) were transferred to the CIU unless they were a.) in need of critical care, in which case they were transferred to the ICU, or b.) they were diagnosed in the surgical ward, or c.) the unit was full.

CDI diagnosis was suspected based on clinical characteristics and confirmed using a 2-step algorithm (positive Glutamate dehydrogenase/toxin assay care test) or a PCR test. Clinical variables and outcomes were compared between the two groups using the χ^2 test and Fisher's exact tests for dichotomous variables and the Wilcoxon rank-sum test for continuous variables.

Variables with a P-value of ≤ 0.10 were tested using multivariable analysis, after which all variables with a P-value of < 0.05 were considered statistically significant.

Results: A total of 176 patients were diagnosed with CDI during the study period. Of these, 85 (48.2%) were transferred to the CIU. In comparison, 91 (51.7%) remained in their OB for various reasons, including the CIU being full at the time of diagnosis, patient transfer to the ICU or another hospital, or patients in surgical wards.

Patients in the CIU experienced a higher recurrence of CDI compared to those in their OB, but the difference was not statistically significant (14 vs. 7, p = 0.081). Patients in the OB group had a significantly higher 30-day mortality compared to the CIU group (34% vs 18.8%, RR: 0.55, 95% CI:0.326 – 0.935; p=0.027)

Multivariate analysis revealed that patients in the OB group had a significantly longer treatment duration (p = 0.001), a higher 30-day mortality rate (p = 0.001), and a higher prevalence of previous surgery (p = 0.001).

Assessment of evidence
Limitations: • Paper is a brief report and is considerably lacking in detail • It is unclear how the data was collected or retrieved. • The suitability of relative risk as an outcome is unclear as this is a retrospective study, but insufficient detail is provided. • No genetic analysis was done to confirm whether recurrence was due to reinfection by a different strain Contributions to review: This paper showed a higher rate of recurrence in patients in the CIU compared to those in the OB. However, the difference was not statistically significant.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Islam, J., Cheek, E., Navani, V., Rajkumar, C., Cohen, J., & Llewelyn, M. J. Influence of cohorting patients with *Clostridium difficile* infection on risk of symptomatic recurrence.	Retrospective Chart review	**Level 3**	Placement in a cohort ward	Management in ward where CDI diagnosis was made	Recurrence of CDI occurring >14 days after initial diagnosis

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Journal of Hospital Infection, 2013:85(1), 17-21.					

Assessment of evidence

Objectives: This paper aimed to identify risk factors for the recurrence of *Clostridium difficile* infection and to determine whether the cohorting of patients increased this risk.

Country: United Kingdom

Background: The study was conducted in an 800-bed acute general hospital in England following the introduction of a bundle of interventions aimed at reducing CDI rates, which included the establishment of an 11-bed *C. difficile* cohort ward and a new antibiotic policy in January 2008. The Cohort ward had two four-bed bays (one for male patients and one for female patients), a double bay, and one side room. All patients had their stethoscope, commode and disposable bed curtains. Gloves and aprons were used for all patients. During the study period, all patients diagnosed with acute CDI were reviewed by the infectious diseases team and admitted to the cohort ward, where possible, as per hospital guidelines. Patients were not transferred to the cohort ward if their clinical needs could not be met there; these include patients in ICU, those requiring renal dialysis and some post-operative surgical patients.

Methods: A retrospective case-record review of inpatients with a confirmed diagnosis of CDI was conducted. Diagnosis was based on stool ELISA (premier toxin A and B; Meridian Bioscience, Cincinnati, OH, USA). Patients were included if they were diagnosed between October 2008 and June 2011. Data extraction from case notes was conducted between January and March 2012, providing a minimum follow-up period of eight months for assessing recurrence or death. Data collected include medication on admission, primary admission diagnosis, burden of comorbidity (assessed using Charlson score), frailty (assessed using Waterlow score), functional ability (assessed using Barthel score), and CDI severity assessment, which was mandated by hospital policy during the study period.

Assessment of evidence
Severe disease was defined as "(i) the presence of ileus or toxic megacolon or (ii) the presence of more than two of the following: fever >38 °C; ≥5 stools passed per 24 h; bloody diarrhoea; abdominal pain, distension, tenderness, or ascites; cardiovascular compromise or dehydration requiring intravenous fluids; white blood cell count >15 or <5 x 10^9 cells/l; and albumin level on the day od assessment <25g/l." Recurrence of CDI was defined as "retreatment based on the clinical judgement of the physician in charge occurring more than 14 days after the day of diagnosis or a positive toxin ELISA test on liquid stool more than 14 days after start of treatment." The primary endpoint used was recurrence within 30 days of CDI diagnosis. Hospital policy at the time was to treat patients with metronidazole for 14 days or with vancomycin if the disease was severe. Results: During the study period, 420 patients were diagnosed with CDI; however, only 312 sets of case notes were available for review. The median age of the patients was 81 years (IQR: 69-87), and 122 (45%) were male. Death without recurrence before 30 days was treated as a competing risk in the assessment of recurrence at 30 days. Hence, 64 patients who died without recurrence before 30 days were excluded from the analysis, leaving 248, with 192 (77.4%) classed as hospital-apportioned and 56 (22.6%) as community-onset cases. Approximately half (55.6%) of the 248 cases were treated on the cohort ward, while the others were managed in the ward where the CDI diagnosis was initially made. Patients in the cohort ward had higher odds of severe disease than those not transferred to cohort wards (OR: 1.95; 95% CI: 1.10e3.46; P = 0.022). Patients transferred to the cohort ward were also associated with an increased risk of recurrence within 30 days of CDI diagnosis compared to those who were not cohorted (OR: 3.77; CI: 1.37-10.35; p = 0.01), as were patients with a UTI (5.15; 2.10-12.64; p<0.001). Other risk factors include severe CDI and the use of antibiotics for infection rather than CDI concomitant with CDI treatment, but these were not statistically significant. The authors also presented a multivariate model, which showed that only transfer to the cohort ward (OR: 3.94; 95% CI: 1.23-12.65; P = 0.021) and urinary infection on admission (OR: 4.27; 95% CI: 1.62-11.24; P = 0.003) remained statistically significant.

Assessment of evidence
Contribution to Study: This study suggests that cohorted CDI patients may be at an increased risk of CDI recurrence. It is, however, unclear whether this recurrence is due to reinfection by a different strain, and the study has several limitations. **Limitations** • No demographic characteristics were provided for the cohort vs the non-cohort group. Hence, it is impossible to determine whether patients in both groups were similar or if similar infection control precautions were applied in both groups. • The multivariate analysis was unclear, and the type of analysis done was not stated. • No isolate typing or gene testing was done to compare the isolates of the initial infection with those from 'recurrence'. Hence, it is difficult to determine the relationship between recurrence and reinfection by a different strain. • The authors also noted the limitations of toxin identification by ELISA alone, concluding that it is no longer considered good practice due to its low specificity. • Hand hygiene compliance was not reported.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Maragakis, L. L., Winkler, A., Tucker, M. G., Cosgrove, S. E., Ross, T., Lawson, E., ... & Perl, T. M. (2008). Outbreak of multidrug-resistant	Outbreak study	**Level 3**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Serratia marcescens infection in a neonatal intensive care unit. Infection Control & Hospital Epidemiology, 2008;*29*(5), 418-423.					

Assessment of evidence

Objectives: This paper describes the investigation of an outbreak of *Serratia marcescens* in a neonatal ICU.

Country: USA

Setting: Neonatal Intensive Care Unit in a 926-bed tertiary care hospital

Background: The NICU consists of 3 rooms or pods (each with 10 adjacent beds), organised around a shared storage and medication-dispensing area, and three smaller isolation rooms containing two beds each. There was a *Pseudomonas* contamination of the sink drains at the time of the outbreak, and hence, a restriction on water usage. Bottled water was used to bathe patients, and staff used an alcohol-based hand sanitiser located at the central charting area of each pod. If the hands were visibly soiled, it was washed with soap and water, after which an alcohol-based surgical scrub was applied. In November 2004, a cluster of six neonates whose cultures grew MDR *S. marcescens* was detected in the NICU. The MDR phenotype identified had not been detected in the NICU before October 2004. More cases were discovered shortly after, and there was a marked increase in neonates colonised or infected with *S. marcescens* compared to the previous 21 months.

An investigation was launched, and microbiology records were reviewed to determine the baseline rate of *S. marcescens* infection before the outbreak as well as to identify cases of infection. Cases were defined as neonates hospitalised in the NICU

Assessment of evidence

from October 2004 through February 2005 who had one or more clinical or surveillance cultures that were positive for MDR *S. marcescens*. MDR *S. marcescens* was defined as any isolate that was susceptible to no more than three classes of antimicrobial agents.

Medical records were reviewed to identify potential risk factors, including low birth weight, younger gestational age, mode of delivery, location of delivery, hospital transfers, underlying diseases, previous mechanical ventilation, central venous catheterisation, nasogastric intubation, and ingestion of breast milk or infant formula. Samples were taken and cultured from various areas of the NICU environment, including counters, bottle warmers, sinks, diaper scales, breast milk, infant formula, equipment in the breast milk room, and air ducts. Each member of the NICU staff was examined for artificial fingernails, dermatitis, or other skin lesions and hand cultures were taken.

Results

Eighteen neonates were identified as infected and/or colonised with MDR *S. marcescens* between October 2004 and February 2005, the majority of whom were in Pod 1 of the NICU at the time of detection. None of the case patients had spent more than 24 hours in pod 3 before acquiring the organism. The baseline rate of *S. marcescens* infection in the 21 months preceding the outbreak was 0.8 cases per month, compared to 3.8 cases per month during the outbreak. Two case patients died during hospitalisation at the NICU, although their deaths were not attributed to the MDR *S. marcescens* infection. Pulsed-field gel electrophoresis (PFGE) analysis revealed that 15 of the 18 case patients were infected or colonised with a single strain of MDR *S. marcescens* (outbreak strain), two patients had a unique, unrelated strain, and the isolate from the 18th patient was not available for analysis (unidentified strain). The outbreak strain and the unidentified strain had similar antimicrobial susceptibility profiles, both resistant to ticarcillin, piperacillin, ceftriaxone, gentamicin, and tobramycin but susceptible to amikacin and gatifloxacin. The two unique strains exhibited distinct antimicrobial susceptibility profiles and were more susceptible to antimicrobials than the outbreak strain.

Hand cultures from NICU staff did not grow *S. marcescens*, and no dermatitis, lesions or artificial fingernails were found when their hands were examined. One sample from a sink drain in Pod 1 yielded a strain of *S. marcescens* that was unrelated to the patients' isolates, as determined by PFGE analysis.

Assessment of evidence

Interventions

Education about Serratia and SICPs was reviewed with NICU personnel, and additional dispensers of hand sanitiser were installed across the NICU. Cleaning and disinfection procedures were also reviewed and reinforced with environmental services personnel. Contact isolation precautions were implemented for all neonates with MDR *S. marcescens* infections who were to be cohorted into a single area of the unit with dedicated staff. The instruction to cohort patients was not initially implemented due to the severity of some patients' illnesses, with staff concerned about the staff-to-patient ratio and the lack of space to accommodate necessary medical equipment, such as extracorporeal membrane oxygenation (ECMO) machines. However, when incidents of the organism continued in January 2005, the Epidemiology and infection control department mandated that all infected or colonised patients be cohorted, and compliance with IPC procedures was reinforced. Staff assignments were changed, more staff were deployed, and beds were closed to accomplish cohorting without compromising patient care. Nursing staff and respiratory therapists were also cohorted to care solely for either affected or unaffected neonates. Wherever possible, physician and nurse practitioner teams examined unaffected neonates first before proceeding to the infected or colonised cohort.

Weekly surveillance cultures of stool and endotracheal tube aspirate were conducted to detect any asymptomatic colonisation of neonates with MDR *S. marcescens*. Neonates who were colonised were placed in contact isolation and cohorted with case patients.

The last case of MDR *S. marcescens* infection with the outbreak strain occurred on Feb 5, 2005.

A case-control study was also reported but was deemed not relevant to the review.

Limitations

- Bundling of interventions; however, this paper has been included because, before the implementation of cohorting, more cases were identified despite the implementation of other measures.

Contribution to review

Cohorting of patients may be an effective strategy for managing *S. marcescens* outbreaks in neonatal settings.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Vonberg, R. P., Kuijper, E. J., Wilcox, M. H., Barbut, F., Tüll, P., Gastmeier, P., ... & Wiuff, C. (2008). Infection control measures to limit the spread of *Clostridium difficile*. Clinical Microbiology and Infection, 14, 2-20.	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This literature review and the recommendations contained in these guidelines were stimulated by the increased incidence of *C. difficile*-associated diarrhoea (CDAD) in multiple institutions and countries across Europe. Control measures for *C. difficile* differ in several important ways from those used to reduce the risk of other nosocomial pathogens. We recommend that this document be used to produce and/or review current local protocols for the control of nosocomial CDAD." Country: Europe The document provides the following recommendations on isolation precautions					

Assessment of evidence
• "If isolation in single rooms is not possible, isolation in cohorts should be undertaken. If there is a lack of capacity, then consideration should be given to using a designated ward or unit for cohort isolation. (IB) Cohorted patients should be managed by designated staff to minimise the risk of cross-infection to other patients. (IB" **Limitations** • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health Information and Quality Authority. National Standards for the prevention and control of healthcare-associated infections in acute healthcare services. May 23, 2017 (Last accessed: 28/08/20205).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: "The revised National Standards are designed to promote a safe and effective infection prevention and control environment within acute healthcare services."

Country: Republic of Ireland

Under Standard 2.5: "Service providers identify and manage a patient's infection prevention and control healthcare needs in a timely and effective manner", the document states the following as one of the features that shows that a service is meeting the standard:

"Arrangements are in place to facilitate isolation of patients with suspected or confirmed communicable disease, including healthcare-associated infection and colonisation with a multidrug-resistant micro-organism. This includes appropriate placement in a suitable and clearly identifiable isolation room, single room or cohort area, in line with best practice. The expertise of the infection prevention and control team is sought regarding isolation prioritisation whenever suitable rooms are not readily available."

The document provides the following definitions in the glossary:

- "Cohort area: a ward or a unit in which a group of patients (cohort) with the same infection are placed together. Cohorts are created based on clinical diagnosis, microbiological confirmation when available, epidemiology, and mode of transmission of the micro-organism."

Limitations

- Although the document states that a review was conducted, it is unclear what type of review it was. The document also mentioned that a summary of the literature review would be published, but this had not been found as of 11 September 2025.
- Update process or schedule not provided.

Question 4: What is staff cohorting, and when should it be implemented?

Evidence added to Literature Review V3.0:

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organization. Clinical management of COVID-19. Living guideline. 13 January 2023 (Last accessed: 20/08/20205).	Guideline	**AGREE Recommend with modifications**	N/A	N/A	N/A

Assessment of evidence

Objectives: “This guideline aims to be trustworthy and living; dynamically updated and globally disseminated once new evidence warrants a change in recommendations for COVID-19.”

The document provides the following strong recommendations with regards to isolation:

“Isolate and cohort patients with suspected or confirmed COVID-19

- Where possible, designate a team of health workers to care for patients with suspected or confirmed COVID-19 and restrict their contact with COVID-19 patients.”

Assessment of evidence
Limitations (and other relevant points) • The evidence underlying the recommendations of interest is also unclear as it has not been directly linked to the recommendations within the document. • The document notes that the WHO commissioned an independent systematic review by the University of British Colombia to consider questions relevant to the present review, but it is not clear how these have been used in the formulation of the recommendations or how the review itself was conducted as the methods are not provided. • This document has been graded 'Recommend with modifications' because, despite the limitations highlighted, it reflects an up-to-date guideline on a pandemic with many uncertainties – which should be considered when it is used to inform recommendations or good practice points. • It should also be noted that this was not the most recent guidance update as of the time of writing. However, it was published on 13 January 2024 and provides the evidence synthesis for the recommendations of interest, which have remained unchanged in the most recent update published on 18 August 2024.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Coia JE, Wilson JA, Bak A, Marsden GL, Shimonovich M, Loveday HP, Humphreys H, Wigglesworth N, Demirjian A,	Guidelines	**AGREE Recommend with modifications**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Brooks J, Butcher L. Joint Healthcare Infection Society (HIS) and Infection Prevention Society (IPS) guidelines for the prevention and control of meticillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities. Journal of Hospital Infection. 2021 Dec 1;118:S1-39.					

Assessment of evidence

"The main scope of the guidelines is to provide advice for the optimal provision of an effective and safe healthcare service while reducing the risk of MRSA transmission in healthcare settings. The guidelines are suitable for patients of all age groups. These guidelines were largely developed with hospitals in mind but may be useful in other settings where MRSA is a concern, for example long-stay units. The guidelines' main focus was the prevention of transmission to patients, thus pre and perioperative care was not included"

Assessment of evidence
On Staff Cohorting, the document provides the following: "GPP 11.3 When considering the need to isolate a patient with MRSA in a single room, other demands on single-room use may take priority and alternative strategies such as nurse cohorting may be appropriate."

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
MacCannell T, Umscheid CA, Agarwal RK, Lee I, Kuntz G, Stevenson KB, Healthcare Infection Control Practices Advisory Committee. Guideline for the prevention and control of norovirus gastroenteritis outbreaks in healthcare settings. Infection Control & Hospital Epidemiology.	Guideline	**AGREE Recommend with modifications**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
2011 Oct;32(10):939-69. Last updated February 15, 2017 (Last accessed: 20/08/2025).					

Assessment of evidence

Objectives: “This guideline addresses prevention and control of norovirus gastroenteritis outbreaks in healthcare settings. The guideline also includes specific recommendations for implementation, performance measurement, and surveillance.”

Country: USA

Summary of Recommendations

Patient Cohorting and Isolation Precautions

- Staff who have recovered from recent suspected norovirus infection associated with an outbreak may be best suited to care for symptomatic patients until the outbreak resolves. (Category II) (Key Question 3.C.5.b)

Limitations

- Most of the underpinning evidence for recommendations related to this review was considered low quality.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Kakimoto K, Nishiki S, Kaga Y, Harada T, Kawahara R, Takahashi H, Ueda E, Koshimo N, Ito H, Matsui T, Oishi K. Effectiveness of patient and staff cohorting to reduce the risk of vancomycin-resistant enterococcus (VRE) acquisition: A retrospective cohort study during a VRE outbreak in Japan. Journal of Hospital Infection. 2023 Apr 1;134:35-42.	Retrospective Cohort Study	**Level 2+**	Hospitalization in the same room with an infector	Hospitalization in a different room but in the same ward as an infector and cared for by the same nurses who cared for infectors Hospitalization in a different room on the same ward, but cared for by nurses who did not care for infectors Hospitalization on a ward with no infectors.	Patient days to positive VREfm test.

Assessment of evidence

Objectives: This retrospective cohort study evaluated the incidence rate of vancomycin-resistant *Enterococcus faecium* (VREfm) in different cohorting/isolation conditions.

Settings: Large hospital with 260 acute and long-term care beds.

Country: Japan

Method

Background: Following the detection of VRE among hospitalized patients in 2019, the hospital began screening for VRE by stool or rectal sampling. VREfm was defined as *E. faecium* with a minimum inhibitory concentration (MIC) of vancomycin <16μg/ml tested at a contract commercial laboratory. The study period was three months – January 1 to March 31st, 2018.

The study population consisted of inpatients in two general wards who were tested by stool or rectal culture at least once during the observation period (there was no routine testing; could cases have been missed?). Patients who tested negative for VREfm were considered susceptible patients, while those who tested positive were considered infectors. The study focused solely on Type A VREfm (tested by PFGE) and excluded patients with other types of VFEfm.

Exposure was defined as contact with patients with Type A VREfm, including patients who had Type A VREfm at the first stool/rectal sampling, inpatients who had it before the study period and those who acquired it during the study period. Exposure was categorised by

- Length of contact time: i.e., time spent by susceptible patients with infectors measured as 1 day, 3, 5, 7, and 14 days. Contact duration was rounded down, e.g., 2.5 days was counted as 1 day rather than 3.
- Degree of space sharing and staff cohorting: This was further categorised as follows
    i) hospitalization in the same room with an infector
    ii) hospitalization in a different room but in the same ward as an infector and cared for by the same nurses who cared for infectors

Assessment of evidence

iii) hospitalization in different room on the same ward, but cared for by nurses who did not care for infectors

iv) hospitalization on a ward with no infectors.

The outcome was a positive VREfm test based on a positive stool or rectal swab culture after having had at least one negative test result previously in the study period. Patient days for a susceptible patient who acquired VREfm were counted from the day of admission or the start of the study period to one day before the positive sample collection day. A patient was an infector on the positive sample's collection day. On the other hand, susceptible patients who did not acquire VREfm had their patient days counted from the day of admission or the start of the study period to the day of the last sample collection or the day of discharge if the patient tested negative after discharge. An infector with two negative results was considered VREfm negative and thought to have lost transmissibility on the first negative sample's collection day.

Results

Within the study period, 272 susceptible inpatients were identified and observed for 4038 patient days. 43 patients acquired VREfm—29 of these were detected as inpatients, and 14 were found to be positive after discharge from the general wards.

The incidence rate (per 1000 patient days) was highest when infectors and susceptible patients were placed in the same room (52.91 (95% CI: 25.34 – 97.3) for 1-day contact; 43.48 (95% CI: 15.96 – 94.63) for a 3-day contact; 45.45 (95% CI: 14.76 – 106.8) for 5-day contact).

This was followed by situations where both were placed on the same ward with the same care team (16.96 (95% CI: 11.44 – 24.21) for 1-day contact; 15.94 (95% CI: 10.97 – 22.39) for a 3-day contact; 14.97 (95% CI: 10.10 – 21.37) for 5-day contact).

It was lower when they were placed in the same ward with a different care team. (8.45 (95% CI: 1.74 – 24.7) for a 1-day contact; 8.26 (95% CI: 2.25 – 21.16) for a 3-day contact; 8.92 (95% CI: 3.27 – 19.4) for 5-day contact)

There were no cases in Wards without infectors.

Assessment of evidence

Compared to placing an infected patient in the same ward as susceptible patients but with a different care team, the incidence rate ratio of VREfm acquisition was significantly higher when they were placed in the same room. 6.26 (1.61 – 35.4, p<0.01) for a 1-day contact, 5.26 (1.25 – 25.35, p=0.01) for a 3-day contact, and 5.1 (1.23 – 20.05 p=0.01) for a 5-day contact.

Using the same comparison, the IRR was also higher when infectors and susceptible patients were placed in the same ward, but the difference was not statistically significant in any period.

Limitations

- The language was ambiguous and sometimes challenging to follow.
- The 14 patients found to have been positive after discharge from the general wards could have had exposure outside the study setting, and thus, including them in the study may overestimate the cumulative incidence.
- Demographic characteristics of patients included were not provided.
- Information on catheterisation being a serious risk factor for VRE infection was not provided or controlled for.
- Patients could have been missed as there was no routine testing.

The authors also noted the following limitations:

- At night, nurses caring for the infected cohort may have cared for the non-infected cohort in the group, which was placed in the same ward with different care teams.
- Confounders such as comorbidities, catheterisation, and antibiotic use, which are themselves risk factors for VREfm, were not considered and controlled for.
- Transmission via HCW who had contact with patients was also not considered.

Assessment of evidence
• Transmissibility was assumed to have started on the sampling day of VREfm detection and ended on the sampling day of the first negative culture or day of discharge. This may not strictly be the case as the 'sensitivity' of single or two consecutive negative cultures for true negatives were reported to be 91.5% and 92.8%, respectively. (Specificity or NPV) Contribution to question The study shows that staff cohorting when VREfm-infected patients are placed in the same ward is associated with a significantly lower IRR of VREfm acquisition compared to when they are placed in the same room. Compared to the former, the IRR is also lower than putting them in the same ward without staff cohorting, but the difference is not statistically significant.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency of Canada. Infection prevention and control for COVID-19: Interim guidance for long-term care homes. June 16, 2021. (Last accessed: 20/08/2025)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "PHAC is updating its interim guidance on infection prevention and control in long term-care homes (LTCHs) to consider emerging data on the transmission of SARS-CoV-2, the virus that causes COVID-19."					

Assessment of evidence
Country: Canada The document says the following on staff cohorting: • "Consideration should be given to having teams of healthcare staff dedicated to caring for residents confirmed to have COVID-19 in separate adequately ventilated units; this may reduce the risk of transmitting infection in the facility." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Department of Health & Social Care and UK Health Security Agency. Infection prevention and control (IPC) in adult social care: acute respiratory infection (ARI). March 28, 2024. (Last accessed	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
September 11, 2025)					

Assessment of evidence

Objectives: “This guidance provides information on infection prevention and control (IPC) measures for ARI, including COVID-19. It applies to adult social care providers, managers of adult social care services and adult social care staff in England.”

Country: England

The document provides the following on staff cohorting:

“Following local risk assessment, outbreak control measures should be considered to manage ARI outbreaks. Outbreak control measures should be proportionate, risk assessed and time limited. Examples of outbreak control measures may include and are not limited to:

- …
- restricting movement of staff who provide care, where possible, for example between wings, or between different care settings (for example for agency staff)
- cohorting of staff to care for symptomatic/positive or non-symptomatic/negative residents (where feasible and safe to do so) …”

“Outbreak control measures can be lifted 5 days after the onset of symptoms in the most recent symptomatic resident. A local risk assessment should underpin the decision to lift outbreak control measures. At this point, care homes should revert to the guidance for management of single cases in section If a service user has symptoms of acute respiratory infection.”

Limitations

- Method of producing guidance not stated.

Assessment of evidence
• Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. Management of acute respiratory infection outbreaks in care homes guidance. July 24, 2024 (Accessed August 19, 2025).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This guidance provides information and advice for health protection practitioners and community infection prevention and control professionals, based in local authorities or in the NHS who have similar responsibilities, and for HPTs in the devolved administrations; when requested to advise on the management of suspected viral ARI outbreaks in Care Quality Commission (https://www.cqc.org.uk/) (CQC) registered care homes for adults in England." Country: England On Staff Cohorting as an outbreak control measure					

Assessment of evidence

"Outbreak control measures are additional to SICPs. Outbreak control measures are time-limited measures whose purpose is to interrupt further transmission and lessen the impact and duration of the outbreak. Outbreak control measures should be proportionate, risk assessed and time limited. Examples of outbreak control measures may include:

- …
- Restriction on movement of staff providing direct care to avoid 'seeding' of outbreaks between different operational units and areas, floors and wings or between different care settings (for example for agency staff)
- Cohorting of staff to care for symptomatic or positive and non-symptomatic or negative residents (as feasible and safe to do so within each operating unit, area or floor"

"In larger homes, separate staff should ordinarily be allocated to either areas (for example units or floors) where there are cases or to areas where there are no cases. This is to limit the risk of infection of residents by staff members. Staff should not ordinarily work at other care homes during an outbreak.

If possible, within an area that has both cases and non-cases, staff should work with only the symptomatic residents or the currently well residents to limit the risk of cross contamination of residents by staff members. Asymptomatic residents living in the areas with cases may have been exposed to a case and could themselves be infectious, or become infectious, so staff working with asymptomatic residents in an affected area of the home should not ordinarily also work with residents in unaffected areas of the home.

The care home may consider preferentially using staff vaccinated against influenza and COVID-19 (vaccinated at least 14 days beforehand) to care for symptomatic residents. Neither vaccine provides complete protection against infection and transmission, with this being particularly limited for COVID-19 vaccination."

"Depending on the causative organism, it can be appropriate for staff who would be at risk of complications if they become infected (for example pregnant or immunocompromised individuals) to avoid caring for symptomatic residents or confirmed cases in their infectious period. A risk assessment will need to be carried out on an individual basis."

Assessment of evidence
Limitations • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
NHS England. Guidance for risk assessment and infection prevention and control measures for measles in healthcare settings.v1.1 24 January 2024 (Last accessed: August 20, 2025).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This guidance is intended to support preparedness for and management of suspected or confirmed measles cases in healthcare settings. It sets out key infection prevention and control (IPC) principles required to prevent transmission of measles					

Assessment of evidence
in healthcare settings and provides resources to support patient screening, triage, management and assessment of risk applying the hierarchy of controls." Country: England The document provides the following on patient placement: "2.2.4. Staff cohorting As an additional infection control measure during outbreaks or incidents, consideration should be given to assigning a dedicated team of care staff to care for patients in isolation or cohort rooms and areas. This can only be implemented if there are sufficient levels of staff available (so as not to have a negative impact on non-affected patients' care). Only staff whose vaccination status, disease history or immune status is known should be assigned to isolation or cohort rooms and areas." **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
World Health Organisation. Transmission-based precautions for the prevention and control of	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
infections – Aide-memoire. 20 June 2022 (Last accessed: 20/08/20205).					

Assessment of evidence

"Transmission-based precautions are used in addition to standard precautions for patients with known or suspected infection or colonization with transmissible and/or epidemiologically significant pathogens. The type of transmission-based precautions assigned to a patient depends on the transmission route of the microorganism: contact, droplet, or airborne."

"Transmission-based precautions must be started as soon as a patient presents with symptoms (e.g. fever, new cough, vomiting, diarrhoea). There is no need to wait for test results."

"Cohorting

- …
- Cohort staff – dedicate health workers so that only a limited number of staff are interacting with patients in isolation."

Limitations

- No methodology for development was provided.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Centers for Disease Control and Prevention. Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease. March 9, 2022 (Last accessed August 28. 2025)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: This guidance provides recommendations for infection prevention and control in healthcare settings for patients who may be infected with a novel influenza A virus (i.e., an influenza A virus of animal origin that has not recently been circulating among humans) associated with severe disease.					

Assessment of evidence
Country: USA On staff cohorting, the document states: • "Facilities should consider dedicating HCP caring for these patients to minimize risk of transmission and exposure to other patients and other HCP." **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Centers for Disease Control and Prevention. Strategies to Mitigate Healthcare Personnel Staffing Shortages September 23, 2022 (Last accessed September 11, 2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: This guidance is for healthcare facilities that are expecting or experiencing staffing shortages due to COVID-19.

Country: USA

The document states the following with respect to 'Crisis Capacity Strategies to mitigate staffing shortages':

"When staffing shortages occur, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care. When there are no longer enough staff to provide safe patient care:

Implement regional plans to transfer patients with COVID-19 to designated healthcare facilities, or alternate care sites with adequate staffing.

If shortages continue despite other mitigation strategies, as a last resort consider allowing HCP to work even if they have suspected or confirmed SARS-CoV-2 infection, if they are well enough and willing to work, even if they have not met all the contingency return to work criteria described above."

"…If HCP are requested to work before meeting all criteria, they should be restricted from contact with patients who are moderately to severely immunocompromised (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:

- If not already done, allow HCP with suspected or confirmed SARS-CoV-2 infection to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
- Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with confirmed SARS-CoV-2 infection, preferably in a cohort setting.
- Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with suspected SARS-CoV-2 infection.
- As a last resort, allow HCP with confirmed SARS-CoV-2 infection to provide direct care for patients without suspected or confirmed SARS-CoV-2 infection. If this is being considered, this should be used only as a bridge to longer term strategies

Assessment of evidence
that do not involve care of uninfected patients by potentially infectious HCP. Strict adherence to all other recommended infection prevention and control measures (e.g., use of respirator or well-fitting facemask for source control) is essential." **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Evidence from previous update(s):

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Vonberg, R. P., Kuijper, E. J., Wilcox, M. H., Barbut, F., Tüll, P., Gastmeier, P., ... & Wiuff, C. (2008). Infection control measures to limit the spread of *Clostridium difficile*. Clinical Microbiology and Infection, 14, 2-20.	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: “This literature review and the recommendations contained in these guidelines were stimulated by the increased incidence of *C. difficile*-associated diarrhoea (CDAD) in multiple institutions and countries across Europe. Control measures for *C. difficile* differ in several important ways from those used to reduce the risk of other nosocomial pathogens. We recommend that this document be used to produce and/or review current local protocols for the control of nosocomial CDAD.”

Country: Europe

The document provides the following recommendations on isolation precautions

3. “Patients with CDAD represent a source for pathogen spread toothers and should be isolated in single rooms whenever possible. (IB)
4. A designated toilet or commode (transportable toilet) for CDAD patients should be provided. (IB)
5. If isolation in single rooms is not possible, isolation in cohorts should be undertaken. If there is a lack of capacity, then consideration should be given to using a designated ward or unit for cohort isolation. (IB)
6. Cohorted patients should be managed by designated staff to minimise the risk of cross-infection to other patients. (IB)”

Limitations

- Update process or schedule not provided.

Question 5: How should patients/residents be assessed for infection risk prior to discontinuing isolation and cohorting?

Evidence added to Literature Review V3.0:

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
National Institute of Health and Care Excellence. Tuberculosis. January 13, 2016. Last updated February 16, 2024. (Last accessed: August 20, 2025)	Guideline	**AGREE Recommend**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This guideline covers preventing, identifying and managing latent and active tuberculosis (TB) in children, young people and adults. It aims to improve ways of finding people who have TB in the community and recommends that everyone under 65 with latent TB should be treated. It describes how TB services should be organised, including the role of the TB control board." On Discontinuing Isolation "Care for people with a continuing clinical or public health need for admission with pulmonary TB in a single room (as a minimum) until they have completed 2 weeks of the standard treatment regimen if they:					

Assessment of evidence

- are unlikely to be rifampicin resistant (that is, do not have risk factors for multidrug-resistant TB) or
- have negative rifampicin resistance on nucleic acid amplification test or culture. [new 2016]"

"Consider de-escalating isolation after 2 weeks of treatment, taking into account the risks and benefits, if:

- the person is showing tolerance to the prescribed treatment • there is agreement to adhere to treatment
- there is resolution of cough
- there is definite clinical improvement on treatment; for example, remaining afebrile for a week
- there are not immunocompromised people, such as transplant recipients, people with HIV and those on anti-tumour necrosis factor alpha or other biologics, in the same accommodation
- the person's initial smear grade was not high; for example, 2 or less
- there is not extensive pulmonary involvement, including cavitation
- there is no laryngeal TB. [new 2016]"

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Carrara E, Ong DS, Hussein K, Keske S, Johansson AF, Presterl E, Tsioutis C, Tschudin-Sutter S, Tacconelli E. ESCMID guidelines on testing for SARS-CoV-2 in asymptomatic individuals to prevent transmission in the health care setting. Clinical Microbiology and Infection. 2022 May 1;28(5):672-80.	Guideline	**AGREE Recommend with modifications**	N/A	N/A	N/A

Assessment of evidence
Objectives: This “guideline addresses the indications for direct testing of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in asymptomatic individuals in health care facilities, with the aim to prevent SARS-CoV-2 transmissions in these settings.” The guidance makes the following recommendations with regards to testing for discontinuing isolation:

Assessment of evidence

- "The panel recommends that a negative PCR test in an asymptomatic individual at least 7 days after being exposed to a confirmed COVID-19 case can be used to shorten the quarantine period (strong recommendation, QoE: low)."

Limitations

This guideline was generally well done. There was clearly considerable rigour involved in its development and a systematic approach was used to search for evidence. However, there are several limitations:

- No external review by experts before publication
- Opinion of patients (or public) not sought – this may be offset by the severity of the situation i.e a global pandemic.
- The search criteria and search strategy are not provided.
- The strengths and limitations of the systematic reviews included in the guidelines are not stated. And even though AMSTAR ratings are provided for each, it is not clear what strengths or limitations informed the rating.

It should also be stated that no systematic reviews were identified for the recommendations relevant to the present review, and the recommendations are based on expert opinion and other level 4 documents. These recommendations are provided under the following two questions, which can be found in p677 of the document:

- Does systematic testing of asymptomatic patients who have been in contact with SARS-CoV-2 cases reduce transmission of SARS-CoV-2 in the health care setting compared to quarantine only?
- Does a negative screening test on a given day allow cessation of quarantine in asymptomatic patients who have been in contact with SARS-CoV-2 cases compared to a predefined quarantine period?

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
MacCannell T, Umscheid CA, Agarwal RK, Lee I, Kuntz G, Stevenson KB, Healthcare Infection Control Practices Advisory Committee. Guideline for the prevention and control of norovirus gastroenteritis outbreaks in healthcare settings. Infection Control & Hospital Epidemiology. 2011 Oct;32(10):939-69. Last updated February 15, 2017 (Last accessed: 20/08/2025).	Guideline	**AGREE Recommend with modifications**	N/A	N/A	N/A

Assessment of evidence
Objectives: “This guideline addresses prevention and control of norovirus gastroenteritis outbreaks in healthcare settings. The guideline also includes specific recommendations for implementation, performance measurement, and surveillance.” Country: USA “3.A.1 Consider extending the duration of isolation or cohorting precautions for outbreaks among infants and young children (e.g., under 2 years), even after resolution of symptoms, as there is a potential for prolonged viral shedding and environmental contamination. Among infants, there is evidence to consider extending contact precautions for up to 5 days after the resolution of symptoms. (Category II) (Key Question 3A) 3.A.2 Further research is needed to understand the correlation between prolonged shedding of norovirus and the risk of infection to susceptible patients (No recommendation/unresolved issue) (Key Question 3A)” **Limitations** • Most of the underpinning evidence for recommendations related to this review was considered low quality. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency of Canada. Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings. Published in 2013, updated November 2016.	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: "This guideline is intended to assist infection prevention and control professionals and all other healthcare providers responsible for developing policies and procedures related to routine practices and additional precautions in all healthcare settings whether in acute or long-term care, ambulatory care, home care or prehospital care settings. This guideline is intended for settings where healthcare is provided."

Country: Canada

The document provides the following on 'Management of patients with airborne infections':

For Varicella:

- "The patient should remain in the room until all lesions have crusted.

Assessment of evidence

- Susceptible personnel and visitors should not enter the room. If exceptional circumstances make this necessary, they should wear a respirator and gloves.
- The patient should leave the room for medically essential purposes only, unless it is established that all other patients and all healthcare workers are immune to varicella. [CII]

For Measles:

- The patient should remain in the room until four days after onset of rash or for the duration of illness, if immunocompromised.
- Susceptible personnel and visitors should not enter the room. If exceptional circumstances make this necessary, a respirator should be worn.
- The patient should leave the room for medically essential purposes only, unless it is established that all other patients and all healthcare workers are immune to measles. The patient should wear a mask when out of the room. [CII]"

The document also provides the following on Management of exposed susceptible roommates and other close contacts

"For Varicella:

…

Exposed susceptible contacts should be placed in single airborne infection isolation room from seven days after the first possible exposure until 21 days after the last exposure."

"For Measles:

…

Exposed susceptible contacts should be placed in single airborne infection isolation rooms from five days after the first possible exposure until 21 days after the last exposure, regardless of vaccine administration (15;492) [CII]"

Assessment of evidence
CII = weak evidence based on “Studies of low quality, regardless of study design or Contradictory results, regardless of study design or Case series/case reports or Expert opinion” **Limitations** • Method of producing guidance unclear. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency of Canada. Updated guidance for infection prevention and control in health care settings when COVID-19 is suspected or confirmed. April 2024 (Last accessed: 20/08/2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence
Objectives: “This document updates the previous guidance document "Update with consideration of omicron: Interim COVID-19 infection prevention and control in the healthcare setting when COVID-19 is suspected or confirmed-December 23, 2021" with revised recommendations for: considerations and implementation of masking for source control administrative controls for screening and surveillance of COVID-19 visitation.” “This guidance is for all healthcare settings (acute care, long-term care, home care and ambulatory/outpatient care).” Country: Canada On Discontinuing precautions “The duration and discontinuation of additional precautions for an individual patient or unit (where precautions may be universally applied during a COVID-19 outbreak) should be determined on a case-by-case basis, in consultation with the IPC program and in accordance with local, provincial or territorial public health guidance and organizational policies. The duration of additional precautions for a symptomatic patient with COVID-19 should be for a minimum of 10 days from onset of symptoms (and a minimum of 10 days from first positive testing for patients who remain asymptomatic), and may be longer dependent upon duration of symptoms, disease severity and the presence of any underlying immunocompromising conditions.” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency of Canada. Infection prevention and control for COVID-19: Interim guidance for long-term care homes. June 16, 2021. (Last accessed: 20/08/2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: “PHAC is updating its interim guidance on infection prevention and control in long term-care homes (LTCHs) to consider emerging data on the transmission of SARS-CoV-2, the virus that causes COVID-19.”

Country: Canada

On “discontinuing additional precautions

The duration and discontinuation of Additional Precautions for an individual resident or unit (where precautions may be universally applied during a COVID-19 outbreak) should be determined on a case-by-case basis, in consultation with IPC expertise and in accordance with local, provincial and territorial public health guidance.

The duration of Additional Precautions for a symptomatic resident with COVID-19 should be a minimum of 10 days from onset of symptoms (and a minimum of 10 days from the first positive test for residents who remain asymptomatic), and may be longer depending upon the duration of symptoms, disease severity and the presence of underlying immunocompromising conditions”

Assessment of evidence
Limitations • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Department of Health & Social Care. Infection prevention and control: resource for adult social care. March 1, 2024 (accessed August 19, 2025).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
This English guidance “contains general infection prevention and control (IPC) principles to be used in combination with advice and guidance on managing specific infections. It is for those responsible for setting and maintaining standards of IPC within adult social care in England.” On discontinuing isolation					

Assessment of evidence
"The decision to stop isolation should be assessed and decided based on individual factors. For example, those who are immunocompromised may shed pathogens for a longer period. Advice from clinicians or infection control teams should be sought as necessary." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. *Candidozyma auris*: guidance for acute healthcare settings. August 21, 2025. (Last accessed: September 10, 2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence
Objectives: “It is designed to support the adoption and implementation of the main guidance within acute healthcare settings. This document should be used in conjunction with the main guidance, which provides the supporting evidence and rationale underpinning these recommendations.” Country: England (Guidance has been agreed for use in Scotland by the SHPN “through the agreed review and adoption process” (see Guide for use in Scotland - Public Health Scotland). On screening policies, the document states the following: “Consider isolating or cohorting contacts of C. auris cases until screening results are available. Contacts may be de-isolated after 3 consecutive negative screens at least 24 hours apart. Inform receiving healthcare providers of C. auris contacts.” **Limitations** • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. Management of acute respiratory infection outbreaks in care homes guidance.	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
July 24, 2024 (accessed August 19, 2025).					

Assessment of evidence

Objectives: "This guidance provides information and advice for health protection practitioners and community infection prevention and control professionals, based in local authorities or in the NHS who have similar responsibilities, and for HPTs in the devolved administrations; when requested to advise on the management of suspected viral ARI outbreaks in Care Quality Commission (https://www.cqc.org.uk/) (CQC) registered care homes for adults in England."

Country: England

On assessment for commencing and discontinuing isolation

"For confirmed COVID-19 residents, they should be supported to avoid contact with others for a minimum of 5 days after the onset of symptoms. They can return to their normal activities after 5 days if they feel well and no longer have a high temperature. If the resident remains unwell, support to stay away from others should continue until they are well and acute symptoms have resolved, usually no longer than 10 days in total. Seek clinical advice for anyone who is still unwell or has a temperature, if not done already.

Post-acute symptoms such as a persistent dry 'post-viral' cough or fatigue do not require ongoing restrictions.

For confirmed or probable influenza, the patient should be supported to stay away from others until symptoms have resolved and for at least 3 days if treated with an influenza neuraminidase inhibitor and 5 days if not treated. There is evidence that older adults and people who are immunosuppressed may shed virus for longer and staff should be encouraged to consider this within an individual risk assessment of symptom resolution. Please see the influenza section for further information.

Assessment of evidence
For seasonal respiratory viruses or ARI without a virological diagnosis, the resident should be supported to stay away from others from onset of symptoms until the resident no longer feels unwell and no longer has a high temperature. This is unlikely to be within 3 days of onset." Table 1 in the guidance provides the following infectious periods for residents "Confirmed Covid-19: Minimum 5 days from symptom onset. Continue supporting to stay away from others until feeling well and acute symptoms have resolved or to a maximum of 10 days. Confirmed or probable influenza, not treated with an antiviral: The patient should be supported to stay away from others for at least 5 days or symptoms have resolved if longer. Confirmed or probable influenza and has been treated with an antiviral: The patient should be supported to stay away from others for at least 3 days, or until symptoms have resolved if longer. Other or unknown viruses: Support to stay away from others from onset of symptoms until the resident no longer feels unwell and no longer has a high temperature (unlikely to be less than 3 days)." On discontinuing outbreak measures "Outbreak measures can be lifted 5 days after the onset of symptoms in the most recent symptomatic resident. A local risk assessment should underpin the decision to lift outbreak control measures. This is long-established as best practice for proportionate care home outbreak control across ARI (1). This is also consistent with the epidemiological characteristics of influenza and later COVID-19 or SARS-CoV-2 variants. See also advice for cases on staying away from others and epidemiology section above, regarding the management of individuals at particular risk of prolonged shedding. All residents should be monitored for up to a further 5 days after this to ensure they can access appropriate treatments where necessary. Further testing in an outbreak should only be done following an HPT risk assessment and on HPT advice in relation to specific concerns."

Assessment of evidence
Limitations • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
European Centre for Disease Prevention and Control. Investigation Protocol for human exposures and cases of avian influenza in the EU/EEA. 2023 (accessed August 19, 2025).	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: This EU "protocol outlines the key steps for case investigation in response to human cases of AIV infection in the European Union and European Economic Area (EU/EEA). It provides guidance for case detection, investigation of other potential cases, testing, contact tracing, case reporting and notification, risk communication and preventive measures. The objective of this					

Assessment of evidence

document is to provide guidance for the investigation and control of a potential avian influenza outbreak in humans. Investigation findings can be used to inform risk assessments."

Country: EU

"Ending isolation of confirmed avian influenza cases

Based on available evidence from AIV and seasonal influenza virus infections in humans, the infectious period can start 1−2 days before symptom onset and usually lasts up to one week after symptom onset. However, long term shedding has been reported (e.g. from children, elderly or immunocompromised individuals) and the exact infectious period of an AIV infection in humans is not clearly defined. This can vary considerably depending on a number of factors including the person's overall health, age and immune response. Therefore, at this stage we are cautious with advice on the duration of isolation and note that the recommendations may change when more information on the infectious period of the AIV strain becomes available.

The following generic guidance can be provided:

- A confirmed case can end isolation after two consecutive negative RT-PCR tests with a one-day interval in-between. It is recommended that the earliest a test should be performed is on Days 7 and 8 from symptom onset.
- If no RT-PCR can be performed to end isolation, the patient can end isolation 14 days after symptom onset or from the sample collection date for the original diagnostic test.
- When long-term shedding is indicated (e.g. in immunocompromised patients that have prolonged RNA shedding with low Ct values) the decision to discontinue isolation should also include an assessment of the clinical and immune status of the case. This is one of the scenarios that presents the highest risk for human adaptation of the virus and particular care must be taken in the assessment of risk when such cases end isolation while the RT-PCR result remains positive."

Limitations

- Method of producing guidance not stated.

Assessment of evidence
• Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
European Centre for Disease Prevention and Control. Considerations for infection prevention and control practices in relation to respiratory viral infections in healthcare settings. February 6, 2023. (Last accessed: 18/08/20205)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: This European document “aims to support the development of guidance for healthcare facilities and healthcare providers in the European Union/European Economic Area (EU/EEA) on infection prevention and control (IPC) measures for the management of patients with respiratory tract viral infection in healthcare settings.” Country: Europe					

Assessment of evidence

Discontinuation of transmission-based precautions

"The duration of transmission-based precautions for hospitalised patients [47] with COVID-19 or other respiratory viral infections should be decided taking into account a number of factors:

- clinical resolution or improvement of respiratory symptoms;
- time elapsed since onset of symptoms;
- severity of disease;
- immune status;
- occupational status and/or susceptibility of those with whom they have regular contact;
- social mixing factors;
- impact of further transmission (e.g. for high impact pathogens);
- evidence of negative RADT or RT-PCR test from the upper respiratory tract.

Any decision on the inclusion of a specific set of the above criteria should be aligned with the risk assessment of the healthcare facility, taking in account the availability of resources and the feasibility of implementing the measures"

"Based on the existing evidence for non-immunocompromised adult patients with COVID-19 and influenza, transmission-based precautions can be discontinued when the following criteria are fulfilled:

1) five days after the onset of symptoms and,
2) resolution of fever for at least 24 hours and,
3) clinical improvement of other symptoms.

Assessment of evidence

Negative RADT or RT-PCR test results for SARS-CoV-2 can also be used to support the decision for discontinuation of transmission-based precautions in patients with COVID-19 [57]. In the event of prolonged RT-PCR positivity for SARSCoV-2 (RNA shedding), high Ct values (≥30) could be used as a proxy of low likelihood of transmissibility, while low Ct values (<24) indicate a higher likelihood of transmissibility, with the caveat that these are not standardised thresholds and differ across laboratories. Wearing a respirator (see 'Definitions') or medical face mask until 10 days after the onset of symptoms or until a negative RADT test is obtained, can be considered as an additional measure.

For immunocompromised or severely-ill patients with respiratory viral infections, longer duration of transmission-based precautions may be necessary due to prolonged viral shedding. Decisions concerning the duration of such precautions should be taken based on clinical judgement and in consultation with IPC professionals. For COVID-19 patients, in addition to the above criteria, two consecutive negative RADT or RT-PCR test results for SARS-CoV-2, ideally with a minimum of a 24-hour interval, should be provided for the discontinuation of isolation, especially if the patient is to be transferred to another unit within the hospital, another hospital, or discharged to a long-term care facility (LTCF).

Similarly, for children hospitalised with influenza longer duration of transmission-based precautions may be necessary due to longer duration of viral shedding. Here too, decisions on the duration of precautions should be taken based on clinical judgement and in consultation with IPC professionals [58]. However, if clinical symptoms and situation allow, children should be discharged with advice on how to prevent transmission at home. For children, and particularly for infants with RSV infection, transmission-based precautions are ideally recommended for the whole duration of hospitalisation, due to prolonged viral shedding."

Limitations

- Method of producing guidance not stated.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
European Centre for Disease Prevention and Control. Guidance on ending the isolation period for people with COVID-19, third update. 28 January 2022	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: “This document provides updated guidance for ending the isolation of people with COVID-19, either home-isolated or inpatients.”

Country: Europe

The documents provide the following on ending isolation:

“Ending of isolation criteria: Decisions on ending isolation need to balance, on the one hand, the risks that an individual who ceases their isolation following a confirmed episode of infection could still transmit the infection to others and the impact of such a transmission, and on the other hand, the impact of isolation on the individual, essential services and society more broadly. This balance should take into account both the likelihood that a recovering case continues to shed infectious virus and what additional measures can be taken to reduce transmission (such as wearing a suitable face mask) and the vulnerability of those the recovering case will mix with (e.g. vulnerable populations in long term care facilities). When deciding on the guidance for criteria on ending home isolation of COVID-19 cases and discharge of COVID-19 patients from hospitals and other healthcare facilities,

Assessment of evidence

health authorities should consider factors such as the existing capacity of the healthcare system, laboratory diagnostic resources and the current epidemiological situation. In addition, factors that may need to be considered by public health authorities when deciding on their guidance for ending isolation of people with COVID-19 include the need to balance the risk of further transmission with the need to ensure continued provision of essential services."

"COVID-19 patients may end home isolation or may be discharged, if hospitalised, after considering:

- clinical resolution or improvement of symptoms;
- time elapsed since onset of symptoms;
- severity of disease;
- immune status;
- occupational status and/or susceptibility of those with whom they have regular contact,
- social mixing factors;
- evidence of negative RADT or RT-PCR test(s) from the upper respiratory tract (Table 1, Figure 1)."

"For hospitalised severe COVID-19 cases available evidence indicates that infectious SARS-CoV-2 virus shedding, irrespective of the VOC, may persist up to up to 20 days.

Any patient needing discharge from a health facility before fulfilling clinical criteria for being unlikely to be infectious and/or without negative SARS-CoV-2 RT-PCR or RADT test results, should be instructed to continue self-isolating at home or at a safe place to complete the necessary duration of isolation (10 days for mild-to-moderate cases, unless two negative RADT or RT-PCR results are obtained before the 10 days elapse; 20 days for severe cases, unless two negative RADT or RT-PCR results are obtained before the 20 days elapse) based on an individual case risk assessment. The assessment should consider the presence of immunosuppression and whether the patient will be in contact with people who are vulnerable to severe COVID-19 and whether they live or work in settings in which there is a risk of large outbreaks (e.g., long-term care facilities (LTCFs), prisons or migrant/refugee hosting facilities). In addition, they should be advised to wear a well-fitting medical or high-efficiency (FFP2)

Assessment of evidence

mask for the remainder of that period, respect physical distancing measures (especially with vulnerable people) and use proper hand hygiene and respiratory etiquette. The patients should seek medical advice if they develop symptoms again.

"…Isolation should continue if the RADT or RT-PCR test results remains positive (even if a self-test RADT). In cases with prolonged RT-PCR positivity (RNA shedding), high Ct values (≥30) can be used as a proxy of low likelihood of transmissibility, while low Ct values (<24) indicate a higher likelihood of transmissibility, with the caveat that these are not standardised thresholds and differ across laboratories. In these cases, the decision to discontinue isolation should also include a assessment of the clinical and immune status of the case, as well as the time from the onset of symptoms and/or more specialised genotyping (see above in RT-PCR positivity section)."

"There is insufficient evidence on viral shedding in individuals with reinfection to enable robust separate recommendations on criteria for ending isolation to be provided for this group."

In Table 1, the guidance on ending isolation for people with COVID-19 provides different criteria for various patient groups.

Limitations

- Method of producing guidance not stated.
- Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Ministry of Health, New Zealand. Guidelines for the Management of Norovirus Outbreaks in Hospitals and Elderly Care Institutions. January 2009. (Last accessed September 12, 2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: This document was "developed to standardise the approach of public health services, managers and health care workers of hospitals and elderly care facilities in New Zealand to both the investigation and control of institutional norovirus outbreaks."

Country: New Zealand

On Patient/resident isolation, the document states the following:

"Place symptomatic patients or residents in contact isolation – preferably a single room with dedicated ensuite or toilet. Post signage, stating the patient or resident is in isolation, on the door of their room or wherever the isolation zone begins. If the patient or resident is vomiting, instigate airborne precautions (see section 7.1.3).

Assessment of evidence
If there are a number of cases, consider cohorting them in the same room(s). Precautions can be discontinued 48 hours after symptoms cease in faecally continent cases.” **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health New Zealand. COVID-19 infection prevention and control guidance for acute care hospitals. March 2024. (Last accessed: 18/08/20205)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: “This guidance is applicable to all district hospitals that are receiving, assessing, and caring for patients suspected or confirmed to have COVID-19 infection or patients who during risk assessment are identified as being at high risk of COVID-19					

Assessment of evidence

infection and outlines the infection prevention and control (IPC) measures to provide a safe workplace for people, patients, and staff in acute care hospitals."

Country: New Zealand.

On Discontinuing Isolation

"The appropriate removal of a patient with infectious COVID-19 from isolation is important to both prevent onward transmission of COVID-19 in health care, appropriately manage single rooms, and optimise patient care. Although legally mandated COVID-19 isolation has been revoked, isolation of 5 days is still recommended.

The onward transmission of COVID-19 may still occur after 5 days, especially in environments with inadequate air handling, where patients share rooms, and where those with COVID-19 are severely unwell or immune compromised."

The document also provides a table for minimal acceptable patient/client de-isolation guidance pathways:

"Immune competent: TTR from day 6, if illness resolving. 1 negative RAT required or PCR with Ct value of >30. or release from isolation day 10 if symptoms resolving. Or follow local guidance.

Immune compromise: TTR from day 10, if immune compromised. 1 negative RAT or PCR with Ct value of > 30. Contact Infectious disease service if RAT still positive at day 16. Or follow local guidance."

*TTR – Test to release

Limitations

- Method of producing guidance not stated.
- Update process or schedule not provided

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Health New Zealand. New Zealand Vancomycin resistant Enterococci (VRE) infection prevention and control guidelines. 12th November, 2024 (Last accessed: 18/08/20205)	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This guidance document has been developed by the VRE Infection Prevention and Control Technical Advisory Group using international guidance and resources to enable healthcare facilities develop their own policies and procedures based on their environment when providing patient care." Country: New Zealand "VRE clearance/removal of alert People may remain colonised with VRE for long periods, in many cases months or years. There is no decolonisation treatment available. It is essential that the Infection prevention staff are involved in decisions regarding clearance and removal of a VRE					

Assessment of evidence
alert. Healthcare facilities should follow local policies. In the absence of these, the following procedure is a reasonable approach to clearance and discontinuation of contact precautions: • Any infection caused by VRE must have resolved • More than 12 months have elapsed since the last positive specimen • Three consecutive VRE negative rectal swabs/faecal samples taken at least one week apart" **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Public Health Agency. Infection Prevention and Control Measures for Respiratory illnesses. March 3, 2023 (Last accessed: 18/08/20205)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: “The IPC principles in this document apply to health and care settings in Northern Ireland and provides guidance for those providing care in non-healthcare settings e.g. community facilities and clients own home. This guidance does not replace existing local protocols that have been developed to support organisations to operationalise other respiratory illness measures.”

Country: Northern Ireland

On discontinuing TBPs

“TBPs should only be discontinued in consultation with clinicians (consider microbiology/IPC team if symptoms remain or patient is immunosuppressed) and should take into consideration the individual’s test results (if available) and resolution of clinical symptoms.

- Stepping down TBP’s if the patient is staying in hospital: For inpatients with respiratory illness, precautions/isolation should continue until the infectious period ends. Advice should be sought from the clinical team depending on what respiratory illness is suspected/confirmed. This guidance does not apply if there are any additional indications for ongoing isolation and transmission based precautions (for example MRSA carriage, *Clostridium difficile* infection, diarrhoea).
- Outpatients/primary care: Patients who are known or suspected to be positive with a respiratory pathogen and whose treatment cannot be deferred should receive care from services who are able to operate in a way which minimises the risk of spread of the virus to other patients. If required, advice can be sought from Infection Prevention and Control Teams.”

Limitations

- Method of producing guidance not stated.
- Update process or schedule not provided

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Norovirus Working Party. Guidelines for the management of norovirus outbreaks in acute and community health and social care settings. March 8, 2012	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: This British guidance was produced by the Norovirus Working Party, a multi-agency group consisting of the British Infection Association, Healthcare Infection Society, Health Protection Agency, Infection Prevention Society, National Concern for Healthcare Infections and NHS Confederation. It "gives recommendations on the management of outbreaks of vomiting and/or diarrhoea in hospitals and community health and social care settings, including nursing and residential homes".

Country: UK

The document provides the following on patient discharge:

a. "Patients can be discharged to their own homes as soon as it is safe to do so GRADE ID
b. Patients can be discharged to care homes which are affected by a norovirus outbreak as soon as it is safe to do so GRADE ID

Assessment of evidence
c. Patients can be discharged to care homes which are unaffected by norovirus when they have been symptom-free for 48h GRADE ID d. Patients can be transferred within hospitals, between hospitals or to other community-based institutions (e.g. prisons) when they are 48h symptom-free. An exception to this will be the transfer of patients between affected clinical areas (e.g. by use of a decant ward) in order to manage an outbreak GRADE ID” The document claims to be developed according to standards set by NHS Evidence and offers graded recommendations. However, it does not provide any additional information on these standards. Furthermore, the provided link leads to a page stating, “We've now closed our evidence search service.” Consequently, this document has been classified as SIGN50 Level 4 guidance.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
UK Health Security Agency. De-isolation and discharge of mpox infected patients. Published 30 May 2022. Updated 12 September 2024.	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: This guidance has been produced by the UK Health Security Agency (UKHSA) to support NHS Trusts in managing the de-isolation and discharge of patients with mpox.					

Assessment of evidence

“Hospital de-isolation criteria

Clinical criteria

The patient is judged clinically well enough for safe de-isolation as judged by the clinical team managing the patient.

Laboratory criteria

The patient is polymerase chain reaction (PCR) negative on all 3 of the following samples:

- EDTA blood*
- urine
- throat swab

*It is acceptable not to send EDTA blood if no sample was sent previously because the patient was well throughout admission.

Lesion criteria

The following criteria all apply:

- there have been no new lesions for 48 hours
- there are no mucous membrane lesions
- all lesions have crusted over, all scabs covering the lesions have dropped off, and intact skin remains underneath

Discharge from an isolation facility or isolation ward to another hospital ward, a different in-patient facility or a residential facility (including care homes and prisons)

Discharge from an isolation facility or ward to another hospital ward, different inpatient facility or residential facility can only be considered if the de-isolation criteria in the clinical, laboratory and lesion criteria sections above are all met.

Assessment of evidence
If there is any doubt, clinicians should discuss virological testing of persistent lesions with the UKHSA Rare and Imported Pathogens Laboratory (RIPL). Transfer of patients from an isolation unit in one hospital to an isolation unit in another hospital may be necessary in certain circumstances prior to the patient meeting all of the above criteria. Such arrangements must be made following case-by-case discussion and agreement between specialists at both institutions." **Limitations** • Method of producing guidance not stated. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Center for Disease Control and Prevention. Prevention and Control for Hospitalized MERS Patients. May 30, 2024 (Last accessed: 20/08/2025).	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence
Objectives: This American guidance provides recommendations for preventing and controlling MERS in hospitalised patients. Country: USA The document recommends the following on ending isolation: • "At this time, information is lacking to definitively determine a recommended duration for keeping patients in isolation precautions. • Duration of precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities. • Factors that would be considered include: presence of symptoms related to MERS-CoV, date symptoms resolved, other conditions that would require specific precautions (e.g., tuberculosis, *Clostridium difficile*), and available laboratory information."" **Limitations** • No methodology for development was provided. • Update process or schedule not provided.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
US Centers for Disease Control and Prevention (CDC). Mpox Infection Prevention and Control in Healthcare Settings. July 8, 2025 (accessed August 19, 2025)	Guidance	**Level 4**	N/A	N/A	N/A

Assessment of evidence

Objectives: This American guidance provide IPC recommendations for the management of Mpox in healthcare settings.

Country: USA

On Patient placement, the document states the following:

On duration and discontinuing of isolation precautions, the document states:

“For patients with suspected or confirmed MPXV infection in a healthcare setting:

- Those with suspected MPXV infection should have recommended isolation precautions for mpox maintained until MPXV infection is ruled out.

Assessment of evidence

- Those with confirmed MPXV infection should have recommended isolation precautions for mpox maintained until all lesions have crusted, those crusts have separated, and a fresh layer of healthy skin has formed underneath.

Decisions regarding discontinuation of isolation precautions in a healthcare facility may need to be made in consultation with the local or state health department, depending on the jurisdiction."

"In general, patients in healthcare facilities who have had an MPXV exposure and are asymptomatic do not need to be isolated, but they should be monitored. Monitoring should include assessing the patient for signs and symptoms of mpox, including a thorough skin exam, at least daily, for 21 days after their last exposure. Postexposure risk assessment and management for patients should be adapted from community guidance or healthcare guidance, depending on the nature and location of a patient's exposure.

During the 21-day monitoring period

If a rash occurs, patients should:

- Be placed on empiric isolation precautions for mpox until (1) the rash is evaluated, (2) testing is performed, if indicated, and (3) the results of testing are available and are negative.

If other symptoms of mpox are present, but there is no rash, patients should:

- Be placed on empiric isolation precautions for mpox for 5 days after the development of any new symptom, even if this 5-day period extends beyond the original 21-day monitoring period.
    - If 5 days have passed without the development of any new symptom and a thorough skin and oral examination reveals no new rashes or lesions, isolation precautions for mpox can be discontinued.
    - Isolation precautions may be discontinued prior to 5 days if mpox has been ruled out.
    - If a new symptom develops again at any point during the 21-day monitoring period, then the patient should be placed on empiric isolation precautions for mpox again, and a new 5-day isolation period should begin.

Assessment of evidence
Some patients may be unable to communicate onset of symptoms (e.g. a newborn, patients with delirium). • For such outpatients, consider use of isolation precautions for mpox for their healthcare visits until they are able to communicate about onset of symptoms (e.g. following delirium resolution) or for up to 21 days after their last exposure. • For such inpatients, consider use of isolation precautions for mpox and monitoring for signs of infection until they are able to communicate about onset of symptoms (e.g. following delirium resolution) or for up to 21 days after their last exposure. Decisions on whether to isolate exposed patients who are unable to communicate about onset of symptoms should be informed by the risk of their exposure incident (how likely they are to develop mpox), risk that transmission would pose to other patients on their unit (e.g., immunocompromised patients), and other factors." **Limitations** • No information provided on how the guidance was developed.

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
US Centers for Disease Control and Prevention (CDC). Infection Control Guidance: SARS-CoV-2.	Guidance	**Level 4**	N/A	N/A	N/A

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
June 24, 2024 (Accessed 19 August, 2025)					

Assessment of evidence

Objectives: "This guidance applies to all U.S. settings where healthcare is delivered, including nursing homes and home health. The recommendations in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency."

Country: USA

"The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a patient with symptoms of COVID-19 can be made based upon having negative results from at least one viral test.

- If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT.
- If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.

If a patient suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described in the Isolation section below. Ultimately, clinical judgment and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions."

"Patients placed in empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the following time periods.

Assessment of evidence

- Patients can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing as described for asymptomatic individuals following close contact is negative.
- If viral testing is not performed, patients can be removed from Transmission-Based Precautions after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms."

"The following are criteria to determine when Transmission-Based Precautions could be discontinued for patients with SARS-CoV-2 infection and are influenced by severity of symptoms and presence of immunocompromising conditions. Patients should self-monitor and seek re-evaluation if symptoms recur or worsen. If symptoms recur (e.g., rebound), these patients should be placed back into isolation until they again meet the healthcare criteria below to discontinue Transmission-Based Precautions for SARS-CoV-2 infection unless an alternative diagnosis is identified.

In general, patients who are hospitalized for SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the time period described for patients with severe to critical illness.

In general, patients should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation below. Then they should revert to usual facility source control policies for patients."

Limitations

- Method of producing guidance not stated.
- Update process or schedule not provided

Evidence from previous update(s):

Study	Study Type	Evidence Level	Intervention	Comparison	Outcome measure
Vonberg, R. P., Kuijper, E. J., Wilcox, M. H., Barbut, F., Tüll, P., Gastmeier, P., ... & Wiuff, C. (2008). Infection control measures to limit the spread of *Clostridium difficile*. Clinical Microbiology and Infection, *14*, 2-20.	Guidance	**Level 4**	N/A	N/A	N/A
Assessment of evidence					
Objectives: "This literature review and the recommendations contained in these guidelines were stimulated by the increased incidence of *C. difficile*-associated diarrhoea (CDAD) in multiple institutions and countries across Europe. Control measures for *C. difficile* differ in several important ways from those used to reduce the risk of other nosocomial pathogens. We recommend that this document be used to produce and/or review current local protocols for the control of nosocomial CDAD." Country: Europe The document provides the following recommendations on ending isolation precautions					

Assessment of evidence
“Isolation precautions may be discontinued 48 h after symptomatic CDAD has resolved and bowel movements have returned to normal (II)” **Limitations** • Update process or schedule not provided.