Handbook for SHEA-Sponsored Guidelines, Expert Guidance Documents, Consensus Statements, and Practice Statements

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Purpose and Guiding Principles

The SHEA Guidelines Committee (GLC) developed this Handbook to support SHEA-sponsored writing groups with a common framework for the development of guidelines, expert guidance documents, consensus statements, and practice statements.

SHEA-sponsored guidelines, expert guidance documents, consensus statements, and practice statements are developed in accordance with these guiding principles:

- **Transparency**: clear documentation and disclosure of methods, roles, decisions, limitations, conflicts of interest, and accountability across authors, committees, and governance bodies.
- **Rigor proportional to purpose**: use of systematic, reproducible methods calibrated to the intent, scope, and evidentiary base of each document type.
- **Independence**: protection from real or perceived undue influence, including avoidance of bias and appropriate management of conflicts of interest.
- **Inclusivity and practicality**: deliberate inclusion of diverse perspectives, expertise, practice settings, and lived experiences, with involvement of interested parties and groups to develop recommendations that are feasible, implementable, and relevant across real-world contexts.
- **Respect for professional judgment**: development of recommendations that balance methodological rigor with responsiveness to inform the clinical and professional judgment of qualified professionals.

Authors

This Handbook is a living document updated at the discretion of the GLC. First published on the SHEA website in January 2016, it applies only to documents developed on or after that date. The Handbook was revised in January 2017, August 2019, December 2021, August 2024, and January 2026 and reviewed and approved by the GLC and the SHEA Board of Trustees in October 2015, January 2017, August 2019, January 2022, October 2024, and October 2026.

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Introduction

- SHEA sponsors four categories of documents that provide recommendations for the practice of infection prevention and control (IPC), healthcare epidemiology, and antibiotic stewardship:
    1. Guidelines
    2. Expert guidance documents
    3. Consensus statements
    4. Practice statements
- Document categories are defined in **Appendix 1** and are assigned at commissioning. Categories may be revised after the initial literature review based on the scope and quality of available evidence; any changes require review and approval by the GLC, Publications Committee, and SHEA Board of Trustees.
- A document's category determines the literature review process used.
- Other SHEA documents, also described in **Appendix 1**, may address relevant or time-sensitive topics, but do not follow the Handbook's evidence review or consensus process. These types of documents are developed at the discretion of the appropriate SHEA committee and SHEA Board of Trustees and are not governed by this Handbook.

Definitions of Guidelines, Expert Guidance Documents, Consensus Statements, and Practice Statements

Document type and methodological approach are determined at commissioning based primarily on the intended purpose of the document, rather than the volume of available literature alone. Methodological elements may be adapted based on topic, evidence availability, and urgency, consistent with this Handbook.

This Handbook provides general definitions for additional formats outside the scope of this Handbook in **Appendix 1**.

Purpose and Methodologies

Feature	Guidelines	Expert Guidance	Expert Guidance (Compendium-style)	Consensus Statements	Practice Statements
Purpose	Definitive, evidence-based clinical or policy recommendations	Evidence-informed expert recommendations when evidence is limited or evolving	Practical synthesis of existing guidance and evidence for implementation	Rapid guidance on time-sensitive or emerging issues	Perspective on programmatic, operational, or administrative practices

Scope	Broad, high-priority topics	Narrow, focused topics	Broader topics with multiple practice domains	Narrow, urgent topics	Programmatic or systems-level topics
Examples	Focused Update Guidelines on Management of *C. difficile* Infection in Adults (2021)	Multisociety Guidance for Sterilization and High-level Disinfection (2025)	Compendium of Strategies to Prevent HAIs in Acute Care Hospitals (2022-23)	Infection prevention and control of *C. auris* in pediatric settings (2026)	Necessary Resources and Structure for Effective Healthcare Facility Infection Prevention and Control Programs (2025)
Manuscript proposal	Required; submitted to GLC and approved by Publications Committee				
Methodology	**Guidelines**	**Expert Guidance**	**Expert Guidance (Compendium-style)**	**Consensus Statements**	**Practice Statements**
Methodologic framework	GRADE or equivalent	Structured, GRADE-informed elements (but not GRADE) with consensus process. Expert guidance does not require GRADE because the questions addressed and the available evidence generally are not well-suited to the methodology	Structured, GRADE-informed elements (but not GRADE) with consensus process	Expert consensus (e.g., Delphi)	Narrative synthesis and expert opinion
Medical librarian involvement	Required			Not required	
Question structure	PICO (population, intervention, comparison, outcome)			Topic-driven questions	May be used but not required
Outcome identification	Required and rated	Identified	Identified	Not required	
Systematic literature review	Required (see **Systematic Literature Review**)			Not required	
Dual, blinded title/abstract screening	Required			Not required	
Full text review and extraction	Required			Not required	
Evidence synthesis	Systematic review with/without meta-analysis	Structured narrative synthesis	Structured narrative synthesis that incorporates existing guidelines and key studies	Non-systematic review	Narrative summary
Evidence quality categories	GRADE or similar	High, moderate, low (see **Appendix 2**)	High, moderate, low (see **Appendix 2**)	Not graded	
Strength of recommendations	Strong or conditional	Strong, conditional, or no recommendation	Essential Practices, Additional	Not assigned	

			Approaches, or no recommendation		
Consensus process	Structured panel consensus	Structured, focused on when evidence is limited or mixed; documented transparently (see **Consensus**)	Structured, focused on prioritizing practices when evidence is incomplete (see **Consensus**)	Formal consensus with voting thresholds (see **Consensus**)	Structured panel consensus
Implementation	Inclusion recommended	Included; informative, not prescriptive	Programmatic and action-oriented	Strategies embedded with recommendations	Strategies embedded with recommendations
Time to development	Variable	32 months		6 months	22 months
Peer review	GLC, Board, external reviewers				GLC or Publications Committee, Board
Publications Committee clearance for publication	Required				
AI use	Permitted use within certain steps of development, with human oversight and published disclosure. See **Use of Artificial Intelligence (AI)**				
Collaboration	**Guidelines**	**Expert Guidance Documents**	**Compendium-style Expert Guidance Documents**	**Consensus Statements**	**Practice Statements**
Organizational representatives	Encouraged		Compendium Partners and additional professional and governmental organizations	Encouraged	
External review	Invitation to involved organizations required				If relevant, invitation to involved organizations
Endorsement	Optional; may be pursued				Optional
Joint development (co-chairs from SHEA and partnering organization; equal panel representation; listed together in title)	Optional		Optional for Compendium-style; required for Compendium	Optional	
Joint publication	Generally discouraged for SHEA-sponsored documents. See **Collaborative Documents and Joint Development**				

Collaborative Documents and Joint Development

SHEA encourages multisociety collaboration to develop consistent, widely vetted recommendations, primarily through organizational representation (see **Writing Panel Composition**).

Collaboration may also take the form of joint development (co-chairs from SHEA and the partnering organization with equal representation on the panel) or endorsement via external review and approval of the final product.

Publication in other organizations' journals or joint publication is rare and requires:

- A memorandum of understanding (MOU) reviewed and approved by the GLC, Publications Committee, Board of Trustees, and journal editors, as applicable.
- Formal agreements among participating societies and publishers regarding editorial responsibility.
- Coordination of dissemination and publicity strategies, which may include websites, social media, and other means of publicity.

Indemnification and Copyright

- Authors of SHEA-sponsored documents approved by the Board of Trustees are covered by SHEA's liability insurance.
- All documents include a standard disclaimer that they do not substitute for individual clinical judgment.[1]
- SHEA retains copyright for all SHEA-sponsored manuscripts and adheres to the copyright policies of its official journals (*ICHE* and *ASHE*).

Writing Panel Composition

Feature	Guidelines and Expert Guidance Documents	Consensus Statements	Practice Statements
Size	Up to 20 authors, including leaders and organizational representatives serving as authors Additional advisors as non-author members	Up to 20 authors, including leaders and organizational representatives serving as authors Additional advisors as non-author members	Smaller; defined by scope
Leaders	Chair(s) and co-chair(s) as identified in proposal and confirmed by GLC and Board.		
Members	Selection will occur from: 1. Applicants to the project-specific call for applications; additional authors may be chosen based on prior SHEA volunteer interest or needed expertise. 2. Organizations invited by SHEA to nominate representatives to serve as authors or advisors. Panel composition confirmed by the GLC, Publications Committee, and Board of Trustees via the manuscript proposal process. Authors may include and are not limited to: 1. SHEA members (clinicians, administrators, researchers) with relevant subject-matter expertise 2. Infection preventionist(s) (IP) 3. Pediatrician(s), when pediatric populations or settings are assessed 4. Antimicrobial and/or diagnostic stewards, when testing, treatment, prescribing, deescalation, or related stewardship considerations are relevant 5. Post-acute or LTC practitioner(s) (PALTC), when applicable 6. Public health expertise 7. Individuals with expertise in areas relevant to the topic (e.g., microbiology, zoonotic disease, travel medicine, environmental sustainability) 8. Organizational representatives serving as authors Advisors: 1. Organizational representatives serving in advisory (non-author) roles 2. Patient and family partner(s) (see **Patient Engagement**)		
Inclusive guiding principles	Panels adhere to the SHEA Inclusive Guiding Principles to, *"Actively implement strategies that incorporate diversity, equity, and inclusion principles to foster a sense of belonging, facilitate innovative solutions, and enhance decision-making"* across gender, race and ethnicity, geography, professional roles, practice settings, and years in practice. The principles are updated annually, and leadership should use the most current version when assembling writing panels.		

[1] "No guidance document can anticipate all clinical situations. This document is not meant to be a substitute for individual clinical judgment by qualified professionals."

Context-specific expertise	Additional relevant specialties, subspecialties, and fields including: infectious diseases, nursing, emergency care, critical care, hospital medicine, diagnostic stewardship, healthcare administration and leadership, healthcare quality, public health, pharmacy, laboratory medicine, care of immunocompromised patients, oncology, hematology, rheumatology, obstetrics and gynecology, fetal medicine, ambulatory care, primary care, home healthcare, environmental services (EVS), incident management and emergency preparedness, legal expertise, patient and family partners (as advisors), veterinary medicine, and zoonotic diseases
Meetings	Panels meet regularly (e.g., monthly) via teleconference and typically do not meet in-person.

Engagement of Patient Partners

SHEA writing panels may engage patient advocacy and interest groups during the scoping and review phases of guideline, expert guidance, consensus, and practice statement development, as appropriate to the document topic. Patient and family partners participate as advisors rather than authors. Potential partners may include, but are not limited to, the National Patient Safety Foundation/IHI, Peggy Lillis Foundation, MRSA Foundation, MRSA Survivors Network, Sepsis Alliance, Empowered Patient Coalition, the Institute for Patient- and Family-Centered Care, Patient Safety Movement Foundation, and Alliance for Safety Awareness for Patients.

Patient advocacy groups interested in participating in SHEA guideline or guidance development may contact info@shea-online.org.

SHEA Conflict of Interest Policy

SHEA agrees with the Institute of Medicine's definition of conflict of interest (COI) as *"a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest."*[2]

Primary interests include protecting the integrity of research, the welfare of patients, and the quality of medical education. Secondary interests may include financial relationships as well as non-financial interests such as professional advancement, recognition, or personal relationships.

Requirements

All authors of SHEA guidelines, expert guidance documents, consensus statements, and practice statements must disclose relevant financial relationships and organizational affiliations at project initiation, annually thereafter, and as updates arise. Authors must also identify appropriate management actions when disclosed relationships are relevant to the content under development.

Disclosable relationships include, but are not limited to:

- Employment or service relationships
- Advisory or consulting roles, particularly related to product marketing
- Ownership interests (excluding diversified funds not controlled by the individual)
- Honoraria (e.g., speakers' bureaus or disease-focused presentations)
- Research funding
- Patents
- Expert testimony
- Participation in governmental or other committees that may limit independent representation of SHEA positions
- Other remuneration (e.g., travel, gifts, or in-kind support not directly related to research)

A statement of "nothing to disclose" indicates that the individual has no financial or non-financial interests that could reasonably be perceived to influence judgment related to the specific document.

Review

Writing panel chair(s) review disclosures and refer those requiring additional consideration to the Conflict of Interest Review Committee. When a potential conflict is identified, the individual must submit a management plan outlining

2 http://www.ncbi.nlm.nih.gov/books/NBK148591/

steps such as recusal or role modification to mitigate real or perceived undue influence. Management plans are reviewed and approved by the Conflict of Interest Review Committee and may apply to voting, drafting recommendations, evidence interpretation, and manuscript approval.

Disclosures are shared with the writing panel, and panel members are responsible for declaring relevant updates at the start of meetings.

Authors' COI disclosures are included in the published manuscript.

Systematic Literature Review

This process applies to expert guidance documents and aligns AGREE II. Guidelines, by contrast, follow GRADE or similar methodology. Practice statements and expert consensus statements do not require systematic literature review.

To promote consistency and minimize bias, search strategies and study selection criteria are defined before data collection. The literature review process is grounded in transparency, consistency, and recordkeeping, and is reviewed with writing groups at project initiation by the writing group chair and SHEA staff.

Consensus

Expert guidance documents and consensus statements use a formal consensus process. Recommendations are presented with rationale that integrates relevant evidence and panel judgment. Discussion and voting on recommendations occur alongside review of the supporting rationale. Consensus is determined through anonymous voting, using thresholds defined in the Consensus Statement Process Guide:

- Consensus: ≥80% agreement on initial vote
- Recommendations with <80% agreement proceed to additional discussion and revote.
  - Majority opinion: 51-100% agreement
  - No recommendation: ≤50% agreement; differing positions are summarized in remarks drafted by the lead authors

Consensus statements are intended to be structured, time-limited documents developed through facilitated discussion and formal voting processes. Voting outcomes determine recommendation classification and reporting. Following panel voting, revisions are expected to focus on clarity, consistency, and accurate representation of panel perspectives rather than reopening substantive consensus decisions, except in cases of major methodological, factual, or safety concerns. Recommendations achieving consensus or majority opinion through formal panel voting will generally proceed without reopening substantive discussion unless major factual, methodological, or safety concerns are identified.
Consensus statements acknowledge that differing perspectives may remain despite structured discussion and voting. Thus, recommendations may be reported as consensus, majority opinion, or no recommendation in accordance with predefined voting thresholds.

Implementation and Sustainability Considerations

Writing panels should consider implementation during recommendation development, including factors around adoption, barriers and facilitators, measurement, fidelity to the recommendation, and sustainability over time. As appropriate to the scope, complexity, intended audience, and anticipated use of the document, panels should include implementation guidance.

When a recommendation is anticipated to have meaningful environmental sustainability implications or tradeoffs, panels should consider these alongside patient and HCP safety, feasibility, healthcare utilization, and unintended consequences. Consideration should be proportional to the topic and does not independently determine recommendation strength.

Standards for Content Neutrality

SHEA-sponsored guidelines and expert guidance documents must use generic names when referencing products, services, or treatments and must not reference organizations whose primary business involves the production, marketing, or distribution of healthcare products used by or on patients.

When guidance documents involve products, services, or treatments, writing panels should assess whether these are vulnerable to discontinuation, shortages, or limited availability. If such vulnerabilities may affect implementation, they should be considered during recommendation development and, when relevant, explicitly acknowledged in the document.

Use of Artificial Intelligence (AI)

SHEA allows the use of artificial intelligence (AI) tools as supportive aids in guideline and guidance development when their use is appropriate, transparent, and subject to human oversight. AI may be used to support language refinement, copyediting, and stylistic improvements to enhance the clarity and consistency of human-authored content. Minimal, non-generative editorial assistance, such as basic spelling, grammar, formatting, or language checking, does not require separate disclosure. Other AI use should be disclosed consistent with the applicable journal and publisher requirements.

Use of AI for methodological support (e.g., literature screening or other components of evidence identification and synthesis) may be considered following appropriate validation and evaluation demonstrating that its use is accurate, reproducible, transparent, and consistent with SHEA's methodological standards. AI-assisted outputs must be verified by the writing panel before use. AI tools do not replace expert review, methodological rigor, or panel decision-making.

AI should not be used to generate or substitute for the underlying intellectual content, expert judgment, evidence interpretation, or recommendations of the writing panel. Substantive content must originate with and remain the responsibility of human authors.

Confidential, proprietary, personally identifiable, or otherwise non-public information should not be entered into AI tools unless use of the tool is authorized and consistent with applicable SHEA and institutional privacy and security requirements.

Manuscript Review and Approval

Methodological Review and Quality Assessment

SHEA evaluates the methodological rigor and transparency of guidelines, expert guidance documents, and consensus statements using a combined checklist informed by AGREE II, ACCORD, the RAND/UCLA Appropriateness Method (RAM), and American National Standards Institute (ANSI). Each applicable criterion is rated as met, partially met, or not met based on the clarity and sufficiency of reporting, or irrelevant when a criterion does not apply to the document type or development approach. This harmonized framework supports consistent review across document types while accommodating differences in scope, purpose, and evidentiary standards.

Internal Review and Approval

SHEA-sponsored guidelines and expert guidance documents undergo structured internal review by an expert panel, if established for the guidance document, and the Guidelines Committee (GLC) and final approval by the SHEA Board of Trustees. The GLC Chair appoints primary reviewers and oversees committee review using standardized forms and timelines. All GLC members without conflicts requiring recusal may provide comments. Writing panels revise drafts and respond to comments in accordance with established procedures.

GLC support of a manuscript is determined by a majority vote of the committee, with recusal of writing group members and individuals with relevant conflicts of interest. Approved documents are forwarded to the SHEA Board of Trustees for final review and approval. Review and approval by the GLC and the Board constitute the official peer review for SHEA-sponsored guidelines and expert guidance documents submitted for publication in *ICHE* or *ASHE*.

Review and approval processes for other SHEA-sponsored document types are also described in **Appendix 1**.

External Review and Endorsement

SHEA pursues external review and endorsement based on topic and context. External review processes, including the use of standardized comment and endorsement forms and processes for engaging patient groups are described in **Patient Engagement**.

- The decision to endorse a SHEA-sponsored document rests solely with the reviewing organization.
- Endorsement by participating organizations is encouraged but not required prior to publication. Publication will not be delayed due to variability in external organizations' review schedules or governance processes.
- Organizations participating in review should clearly identify any changes required for endorsement using the standard comment form.

Organizations invited to review may provide comments and indicate endorsement, endorsement with comments, or non-endorsement with rationale. Comments are reviewed by the writing panel chair, who determines incorporation and documents the rationale.

To support timely publication while maintaining transparency:

- Organizations that provide review are acknowledged in the manuscript.
- Organizations that complete endorsement prior to publication are listed in the published document.
- Organizations that endorse after publication are acknowledged on the SHEA website, which serves as the authoritative, up-to-date record of endorsements.

Periodic Review of Existing SHEA Guidance Documents

SHEA maintains its guidelines and expert guidance documents through periodic review to determine whether updates are needed or whether documents have become obsolete. The GLC may retire documents deemed obsolete; retired documents are maintained separately on the SHEA website.

Guidelines and expert guidance documents are generally reviewed on a 4-year cycle. The *Compendium of Strategies to Prevent HAIs in Acute Care Settings* is reviewed every 5 years. Reviews may be triggered earlier by substantive changes in evidence, outcomes of interest, available interventions, professional consensus, or healthcare resources.

Periodic review procedures, including assignment of reviewers and assessment criteria, follow standardized processes described in **Appendix 1**. When an update is approved, a new expert panel is convened through the manuscript proposal process. Panel composition may include prior members but is reviewed and approved by the GLC and the SHEA Board of Trustees, and all panelists must comply with current SHEA conflict of interest policies.

The development, review, and approval of updated documents follow the same processes outlined in this Handbook for new guidelines and expert guidance documents. Documents undergoing revision are flagged on the SHEA website to indicate that an update is in progress.

Appendix 1: Definitions of SHEA-Sponsored Documents

Development, review, and publication processes as outlined in the Handbook apply to guidelines, expert guidance documents (including Compendium documents), consensus documents, and practice statements. Development of other manuscript types are beyond the scope of this Handbook.

Type of Manuscript (*indicates documents governed by this Handbook)	**Definition**	**Overseen by**	**Reviewed by**	**Peer Reviewer** (applicable to SHEA-sponsored documents submitted for publication in ICHE)	**Example**
Compendium*	Synthesis of evidence and current guidelines for the prevention of HAIs with intervention, special precautions, and implementation strategies	GLC	• GLC • Board • Expert Panel • Advisory Panel • External participants (Partners, endorsing and sponsoring orgs) • Publications Committee (publications process and potential to affect impact factor)	GLC, Board	Compendium of Strategies to Prevent HAIs in Acute Care Hospitals (2022-23)
Consensus Statement*	Recommendations based on non-systematic literature review and consensus of experts	GLC	• GLC • Board • External participants • Publications Committee (publications process and potential to affect impact factor)	GLC, Board	Infection prevention and control of *C. auris* in pediatric settings (2026)
Expert Guidance*	Guidance based on systematic literature review and consensus of experts	GLC	• GLC • Board • External participants • Publications Committee (publications process and potential to affect impact factor)	GLC, Board	Multisociety Guidance for Sterilization and High-level Disinfection (2025)
Guideline*	Evidence-based guidance conducted via GRADE or similar methodology	GLC	• GLC • Board • External participants • Publications Committee (publications process and potential to affect impact factor)	GLC, Board	Focused Update Guidelines on Management of *C. difficile* Infection in Adults (2021)
Brief	Clarification or update to existing document (guideline, practice statement, position paper)	Relevant committee (GLC, Education,	• Overseeing committee • Board	N/A (published online)	Reply to Diekema et al. "Are contact precautions "essential" for the prevention of healthcare-associated

		Research, PPGA, etc.)			methicillin-resistant *Staphylococcus aureus?"* SHEA Public Letter Regarding 2010 Bloodborne Pathogen Guideline (Sept. 2014)
KSA	Knowledge, skills, and abilities articles	Relevant committee	• Overseeing committee • Education Committee • Publications Committee • Board	Publications Committee, Board	Guidance for the Knowledge and Skills required for Antimicrobial Stewardship Leaders: an update from SHEA, IDSA, PIDS, SIDP
Position Paper	Society or collaborative statement regarding regulatory and public policy actions	PPGA	• PPGA • External participants • Board	N/A (published online)	Letter to HHS Sec. Robert F. Kennedy Jr. in support of the Healthcare Infection Control Practices Advisory Committee (HICPAC)
Practice Statement*	Society or collaborative statement summarizing views on healthcare epidemiology program-related practices, administrative policy, or statements about the state of the field	Relevant committee (GLC, Education, Research, PPGA, etc.)	• Overseeing committee • Publications Committee • Board • External participants	Publications Committee if it does not include practice recommendations, Guidelines Committee if it does include practice recommendations; Board	Necessary Resources and Structure for Effective Healthcare Facility Infection Prevention and Control Programs (2025)
Commentary	Expert opinion/editorial related to guideline, practice statement, or position paper	Relevant committee (GLC, Education, Research, PPGA, etc.)	• Overseeing committee • Publications Committee • Board • External participants	Publications Committee, Board	SHEA supports environmental stewardship and sustainability while protecting patients and healthcare personnel position statement of the SHEA Board

Appendix 2: Recommendations and Evidence Classifications

Adapted based on GRADE, the *Update to the CDC and the HICPAC Recommendation Categorization Scheme for Infection Control and Prevention Guideline Recommendations,* and the *2022 Compendium of Strategies.*

Classification	Expert Guidance	Compendium or Expert Guidance (Compendium-style)
Recommendation strength	**Strong recommendation**: the panel judges that the recommendation is supported by sufficient evidence and expert consensus such that it is expected to apply to most settings and circumstances	**Essential practice**: the panel judges that the benefits of the recommended approach clearly outweigh the harms (or, for negative recommendations, that harms clearly outweigh benefits)

	Conditional recommendation: the panel judges that the benefits of the recommended approach are likely to outweigh the harms, but that applicability depends on context, values, resources, feasibility, or patient population, and that alternative approaches may be appropriate	**Additional approach**: the panel judges that the benefits of the recommended approach are *likely* to outweigh the harms (or, for negative recommendations, harms are likely to outweigh the benefits), but the approach is not considered essential and may be implemented selectively or as a supplement to core practices
	No recommendation: the panel determines that available evidence or consensus are insufficient to support a recommendation, which may reflect uncertainty in the balance of benefits and harms, substantial variability across settings or populations, or important evidence gaps	**Unresolved issue**: panel members agree that there is both a lack of pertinent evidence and an unclear balance between benefits and harms
Quality of evidence	Reflects the panel's assessment of confidence in the body of evidence supporting a recommendation based on study design, consistency, directness, and identified limitations. • **High**: further research is unlikely to change confidence in the evidence • **Moderate**: further research may affect confidence or estimates of effect • **Low**: evidence is limited or uncertain; recommendations rely more on expert judgment.	

Appendix 3: SHEA Inclusive Language Guide

Introduction

Language evolves over time and requires periodic updates to ensure clarity and consistency. For organizations that develop guidance for healthcare safety, using clear and standardized terminology is essential to effective communication among patients, healthcare personnel, and other interested persons and groups. Language that is unclear, inconsistent, or exclusionary can contribute to disparate care experiences and undermine trust among the populations these documents are meant to protect[3].

The Handbook Task Force developed this guide to support consistent language across SHEA expert guidance, guidelines, research manuscripts, and other written materials. It focuses on terminology and phrasing that are relevant to SHEA, feasible for authors to adhere to consistently, and understandable by users of SHEA's materials.

This guide is not exhaustive, and both terminology and usage will continue to evolve. Authors are encouraged to consult reputable external sources as needed, such as the American Psychological Association Inclusive Language Guide. The document will be reviewed and updated periodically and aligns with the SHEA Diversity, Equity, & Inclusion Pledge.

General principles

As appropriate, authors should:

- Provide definitions as needed for clarity.
- Use terminology that is appropriately specific for the purpose of the work and be able to explain the reasoning for specificity or differentiation.

[3] APA 2nd Edition Inclusive Language Guide (2023). American Psychological Association. (2023). Inclusive language guide (2nd ed.). https://www.apa.org/about/apa/equity-diversity-inclusion/language-guidelines.pdf

- Choose terminology and phrasing that respect individual identity and, when uncertain, consult reputable sources for prevailing usage.
- Use labels thoughtfully and avoid making assumptions when applying descriptors.
- Apply consistent terminology throughout the document.
- Include appropriate corollaries to avoid implying a "norm" and an "exception."
- When citing or describing a study that did not follow these principles, use the original terminology as needed to accurately inform the guidance or guideline.

Terminology

Those who work in healthcare

- For all paid and unpaid persons who serve in healthcare settings and whose primary intent is to protect or improve health, use **healthcare personnel (HCP)** (CDC)**.** When appropriate, HCP may be referred to collectively as the **healthcare workforce.**
- As relevant and needed for clarity, authors may use the CDC definition of HCP, which encompasses all persons, paid and unpaid, who serve in healthcare settings and "have potential for direct or indirect exposure to patients or infectious materials," OR subset HCP as follows:
    - **Non-clinical healthcare personnel (non-clinical HCP)** for those who do *not* work in clinical care spaces.
    - **Clinical healthcare personnel (clinical HCP)** for those who work in clinical care spaces. Clinical HCP may be further differentiated as:
        - Patient-interacting HCP
        - Prescribing HCP: individuals with authority (through licensure or employer authorization) to make treatment decisions for patients
        - Non-patient-interacting HCP.

Visitors and support persons

- For individuals who enter a healthcare facility but are *not* patients, HCP, or persons in non-health related roles (e.g., restaurant employees), use **visitors**.
- To describe a visitor who is a primary source of support for the patient's activities of daily living (ADL), labor and delivery, or a procedures and recovery, use **support person** or **primary caregiver**, selecting the term most appropriate for the population and context.
- To describe a visitor's potential exposure resulting from close or sustained contact with a patient who has a communicable disease, use **time or proximity-based definitions specific to the infectious agent**, rather than "household contact." After defining these conditions in the document, authors may use **close contact** for conciseness.

Person-first and identify-first language

- Describe people in ways that preserve individual integrity. Use broadly inclusive language unless specificity is required for the purpose of the communication.
- At the outset, identify conditions and situations that may be relevant to the populations and scenarios discussed (e.g., illness, disease, living situation, sexual activity or identity, gender identity, language, ethnicity, citizenship status):
    - In general, recognize a person before their condition or situation. (e.g., "person with…", "person experiencing…", "a person who is...")
    - Exceptions apply:
        - Use an individual's preferred terminology, when known.
        - Some groups may prefer identity-first language. Per APA guidance, either person-first or identify-first language, or a combination, may be used until a clear group preference is established.
    - Preferred phrasing varies by context and population; consult reputable sources as needed.

- Avoid describing people by sexual activity. When necessary, describe the relevant activity or body part(s) (e.g., persons who have anal receptive intercourse), using prevailing, evidence-based terminology.

Gender

- Apply the same person-first and identity-first principles, respecting individuals' identities.
- Before beginning the project, identify which gender-related considerations are relevant to the populations and scenarios discussed; consult reputable sources when uncertain.
- Use *individuals*, *persons*, or *people* to refer to human beings. *Persons* may be used to emphasize individuals within a collective.
- Use gender-inclusive occupational nouns such as *chair* or *chairperson* (NIH).
- Use gender as an adjective, not a noun (e.g., *female* person).
- Use the singular, gender-neutral pronouns *they/them* unless differentiation is demonstrably necessary (APA, HHS).
- Use *gender* and *sex assigned at birth* classifications appropriately:
    - *Gender* refers to social identity
    - Avoid references to *sex* or *sex assigned at birth*, unless necessary; when used, apply person first phrasing (e.g., *people raised female/male*) (SAGE).
- As of this writing, *transgender* and *gender nonconforming* are generally accepted terms (SAGE).
- Avoid assumptions and use corollaries consistently (e.g., if referring to *people who are transgender*, also include the corollary *people who are cisgender*) (SAGE).

Pregnancy, birth, and lactation

For pregnancy, birth, and lactation terminology, follow guidance from ACOG, AAP, or similar reputable sources; in general, use gender-neutral terms (e.g., *pregnant person* or *lactating person*).

Race and ethnicity

- Do not present race or ethnicity as biological variables. Include racial or ethnic information only when relevant and state the reason for inclusion (e.g., to describe systemic disparities). Avoid reporting these variables in isolation (JAMA).
- When collecting data, allow individuals to self-identify race and ethnicity.
- Use racial and ethnic terms as adjectives, not nouns.
- Consider geographic and regional context in terminology; consult reputable sources when uncertain.
- Capitalize the names of races, ethnicities, and tribes (JAMA).

Age

- For individuals aged 18 and older, use specific ages or age ranges rather than descriptors, which are variably defined (e.g., *persons over age 65* rather than *older adults*).
- For pediatric populations, use age categories defined by AAP (e.g., *neonate, infant, child, adolescent*). If alternative terms are used, explain why.

Interested persons and groups

For individuals or groups who may be interested in or affected by a decision or action, use **interested persons and groups**, rather than *stakeholders* or *working partners*. The former avoids historic connotations and better reflects the breadth of those relevant to implementation.

Practice statement

- The term **practice statement** replaces *white paper* and refers to documents that summarize views on healthcare epidemiology and antimicrobial stewardship program-related practices (e.g., infrastructure, business cases, quality outcomes and metrics, etc.).
- Practice statements do not follow the literature search or evidence review processes outlined in this Handbook.

Resources

The following resources may be consulted for current terminology and inclusive-language considerations. Recommendations may vary across sources and change over time; authors should use terminology appropriate to the population, clinical context, and intended audience.

CDC Preferred Terms for Select Population Groups & Communities
AAFP
Agency for Healthcare Research and Quality Priority Populations
American Psychological Association APA Style: Bias-Free Language
APA Inclusive language Guide *(2nd ed., 2023)*
Health Resources & Services Administration
JAMA
NIH person-first language
SAGE Publications

Appendix 4: Acronyms

ASHE	Antibiotic Stewardship & Healthcare Epidemiology (SHEA journal)
CDC	Centers for Disease Control and Prevention
GLC	SHEA Guidelines Committee
GRADE	Grading of Recommendations Assessment, Development and Evaluation
HICPAC	Healthcare Infection Control Practices Advisory Committee (CDC)
ICHE	Infection Control and Hospital Epidemiology (SHEA journal)
SRN	SHEA Research Network