CHAPTER 8 – INFECTION PREVENTION AND CONTROL

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SUMMARY OF RECOMMENDATIONS

- Core infection prevention and control (IPC) guidance is available in the National Clinical Guideline No. 30. This chapter should be used in conjunction with these guidelines across all relevant services in Irish healthcare settings.
- Organisational support is required to ensure that infection prevention and control is effective at the clinical level.
- Institutional risk assessment for TB prevention should be conducted, agreed and reviewed on an ongoing basis through local governance structures. This supports preparedness planning and proactive approaches to TB management.
- The application of standard precautions for everyone, regardless of their perceived or confirmed infectious status ensures safe work practices. Implementing standard precautions as a first-line approach to IPC where healthcare is provided minimises the risk of transmission from person to person, even in high-risk situations.
- As part of standard precautions, a point of care risk assessment (PCRA), should be undertaken as this will inform the level of IPC precautions needed, including the use of personal protective equipment (PPE), and appropriate patient placement.
- In acute healthcare settings, patient placement should be in a negative pressure single room (where available), for people with suspected or confirmed infectious pulmonary or laryngeal TB.
- Supporting documents are available to guide and support decision making regarding patient placement, where negative pressure rooms are unavailable.
- Wear correctly fitting and fit checked respiratory protection (FFP2/3 respirator) when entering the patient- care area where an airborne-transmissible infectious microorganism is known or suspected to be present, such as TB.
- Alert visitors to check with ward nursing staff regarding IPC precautions such as hand hygiene, and assist visitors with precautions such as supporting them, as appropriate to fit check following application of a respirator mask as necessary, before and after visiting.

- Provide plain language patient information which offers general advice including respiratory hygiene, the safe disposal of tissues and the importance of hand hygiene after coughing/ sneezing; including translations where needed.
- General advice for the management and care of patients in non-acute and non-healthcare settings with suspected or confirmed infectious pulmonary TB with signposting to relevant resources.
- Provide an appendix outlining a suite of IPC supportive resources to guide staff.

8.1 Introduction

This chapter outlines the Infection Prevention and Control (IPC) measures required to prevent transmission of *Mycobacterium tuberculosis* (TB) in healthcare and relevant non-healthcare settings. It must be read in conjunction with the Department of Health (2023) **National Clinical Guideline (NCG) No. 30 - Infection Prevention and Control**. NCG No. 30 (**Appendix 1**) provides the overarching IPC framework, including standard and transmission-based precautions. This chapter provides TB-specific application of those principles.

8.2 Governance and Institutional Risk Assessment for TB Prevention

For IPC to be effective in clinical settings, strong organisational support is essential. IPC must be fully integrated into governance and management structures.

Key organisational requirements include:

- providing resources proportionate to the scale and complexity of the service
- implementing vaccination programmes
- ensuring access to Occupational Health services to protect healthcare workers
- establishing surveillance systems that contribute to quality and patient safety programmes
- delivering ongoing staff education and training,
- incorporating IPC considerations into planning for facility design and maintenance.

Identifying and analysing risks associated with healthcare is an integral part of successful IPC. A risk-management approach must be adopted at all levels of the organisation. Responsibility for this lies primarily with facility management, but it requires collaboration between management, healthcare workers and support staff, and the cooperation of people using healthcare services and visitors. Each healthcare service and facility must assess risks within its own specific context and determine appropriate control measures. Differing types and

levels of risk exist in different healthcare settings. Regular IPC risk assessments are therefore essential, and all staff must understand their individual and collective responsibilities in managing these risks.

8.2.1 Specific institutional risk assessment for TB Prevention

There should be a focus on proactive strengthening of institutional level IPC measures in order to recognise cases of TB and prevent TB transmission, as appropriate. This proactive approach should reduce the risk of an outbreak of TB.

A suite of risk assessment resources for TB control are available from the **CDC** and **WHO** websites.

Facility-level risk assessments should consider:

- Likelihood of TB presentations in the setting
- High-risk clinical areas (e.g. emergency departments, respiratory units)
- High-risk environments (including prisons, long-term residential care facilities)
- Personal protective equipment (PPE) supply and staff competency: including availability, training and education of staff, fit testing staff for FFP2/ 3 respirator masks, as appropriate
- Case and outbreak preparedness and response plans for TB
- Capacity for airborne isolation: monitoring/ maintenance/ and validation of negative pressure rooms in acute healthcare settings

These risk assessment tools can be adapted locally to suit individual facilities, and these should be agreed and reviewed on an ongoing basis through local governance structures.

8.3 General principles

Standard precautions refer to those work practices that are applied to everyone, regardless of their perceived or confirmed infectious status. Standard precautions ensure a basic level of IPC. Implementing standard precautions as a first-line approach to IPC where healthcare is provided minimises the risk of transmission from person to person, even in high-risk situations.

Control of spread, as used to control other infectious diseases, is based on the same principles and precautions (including standard precautions and transmission-based precautions)

8.4 Healthcare settings

8.4.1 Management of patients with suspected or confirmed infectious pulmonary or laryngeal TB in healthcare settings

Proactive preparedness planning and institutional risk assessment should ensure healthcare settings have systems to promptly identify people with suspected infectious or confirmed TB before or at initial presentation (first contact), for example at triage, emergency departments, primary care settings, medical assessment units etc.

A point of care risk assessment (PCRA) should be completed before every patient interaction. PCRA determines required precautions, appropriate PPE, and patient placement. PCRA resources are available on the following **link.**

Standard precautions apply to all patients at all times. Airborne precautions must be implemented for suspected or confirmed infectious pulmonary or laryngeal TB.

Where TB is suspected:

- Minimise time in shared waiting areas
- Offer the patient a surgical mask
- Expedite placement in a single room.

8.4.1.1 Patient placement in acute healthcare settings

People with suspected or confirmed infectious pulmonary or laryngeal TB should be placed in a negative pressure single room (where available), including those who will remain in a hospital setting and those attending emergency/ assessment units, outpatients or receiving inpatient care.

It is important to minimise the person's waiting time in assessment areas, where possible. This may involve prioritising their care above that of other patients.

Assessment areas without isolation rooms with controlled ventilation system must have a process in place to prioritise transfer of suspected or confirmed infectious pulmonary or laryngeal TB cases to a single room, as soon as possible.

Place a surgical mask on the patient and place him/ her in an examination room while awaiting transfer to a single/ isolation room.

Ensure that local IPC practices are completed for **standard and transmission-based precautions.**

Do not admit people with suspected or confirmed infectious pulmonary or laryngeal TB to a ward containing people who are immunocompromised, such as transplant recipients, etc. unless they can be cared for in a negative pressure room on the same ward.

8.4.1.2 Isolation rooms with ventilation

Patients with suspected or confirmed TB who require admission should be placed in a room with bathroom facilities and with appropriate controlled ventilation/ negative pressure room as per HBN 04-01 or in a room from which air does not circulate to other areas, if available. It is important that there are local processes in place ensuring that engineering and validation is conducted by designated personnel and ongoing audit is scheduled with oversight and monitoring at a hospital level.

If it is not possible to place a patient in a negative pressure isolation room, make an assessment of the various risks associated with other patient placement options, which may require prioritising single rooms for patient placement. At a minimum, a single room with dedicated ensuite/ bathroom facilities should be used with adequate ventilation when negative pressure rooms are unavailable should be justified by risk assessment.
The use of **supporting documents** are available to guide and support decision making in consultation with the IPC team.

Refer to the following guidance documents to support decision making:

- HSE AMRIC Guideline: **Guide to prioritisation of patients for single room isolation when there are not sufficient single rooms for all patients that require Isolation.**
- **V3.0 Guidance on Balancing Competing Demands in Relation to Restrictions on Bed Use Related to Infection Prevention and Control in Acute Hospital settings.**

Consistent with the person's care needs it is good practice to minimise the number of staff and length of time that healthcare workers are exposed within shared airspace with a person on airborne precautions.

8.4.1.3 Use of personal protective equipment (PPE)

As part of standard precautions, it is the responsibility of every HCW to undertake a **point of care risk assessment (PCRA),** (a poster and explainer document resources are available to

guide staff) prior to performing a clinical care task; this will inform the level of IPC precautions needed, including hand hygiene, appropriate choice and use of personal protective equipment (PPE), and appropriate patient placement.

In addition to the use of PPE as part of Standard Precautions, respiratory protection is advised for health and care workers when airborne precautions are applied.

8.4.2 Management of known or suspected cases

Rapid identification and isolation of patients are key preventive measures, along with the appropriate choice of PPE following a PCRA.

A PCRA will help the health and care worker to determine if the patient is a known or suspected TB case and will guide them to wear an FFP2 respirator mask as a minimum and as part of transmission-based precautions.

8.4.2.1 Staff who are caring for patients with known or suspected TB

Respirator masks are designed to help reduce exposure of the wearer's airway to airborne contaminants such as particles, gases or vapours. It is necessary to wear correctly fitting and fit checked respiratory protection (FFP2 respirator) when entering the patient-care area where an airborne-transmissible infectious microorganism is known or suspected to be present, such as TB. In order for an FFP2 respirator to offer the maximum desired action the wearer should be properly fitted and trained in its safe use.

Healthcare workers are encouraged to observe each other's mask fitting and immediately advise of any fitting issues to maximize healthcare worker safety and safety of those who use healthcare services.

The Health and Safety Authority indicate that where a risk assessment indicates that HCW's need to use a close-fitting respirator mask for their protection that every effort should be made to comply with the requirement for fit testing of the worker, as far as is reasonably practicable. When fit testing of all staff is not immediately possible, then fit testing should be prioritised for those at greatest risk.

Priority groups for fit testing include the following:

- HCWs most likely to be involved in performing aerosol generating procedures (AGPs), in particular endotracheal intubation

- HCWs most likely to have the most frequent or prolonged exposure to airborne infection.
- Arrangements for fit testing should be coordinated at a local level through appropriate governance arrangements.

Tips for respirator facemasks:

The wearer must:

- Fit check each time a respirator is worn, to ensure there are no gaps between the mask and face for unfiltered air to enter;
- Must change the mask if wet or damaged and once removed they should be disposed of and not reused. Check to determine if respirator masks are fluid repellent
- For potential aerosol generating procedures, staff should wear eye protection (use visor/ eye protection), as part of PCRA.
- Posters are available to support **fit checks** and fit testing/ fit checking resources are available in the NCG no. 30, see **Appendix 1** for further details.

8.4.3 Management of patients with suspected or confirmed infectious pulmonary TB whilst an in-patient

Caring for people with a continuing clinical or public health need for admission with confirmed/ suspected infectious pulmonary TB, whilst they are an inpatient in a hospital setting, airborne isolation precautions must be commenced, and the patient placed in a single room. If remaining in hospital, patients should be cared for in a single room until they have completed 2 weeks of the standard recommended treatment regime for drug-sensitive TB, or they are discharged from hospital. If patients have to leave the isolation room they should be advised and supported to wear a surgical face mask until at least 2 weeks after starting effective treatment in conjunction with consideration of clinical and laboratory evidence of response to treatment or until TB is excluded.

If drug resistance is suspected, then cases should remain in isolation with airborne precautions in place until susceptibility results are confirmed. If sputum remains smear positive, a decision about hospital discharge should be made in consultation with a specialist physician with experience in managing TB and taking into account the person's social circumstances.

Prior to discharge, agree arrangements for supervising and administering TB therapy with the person and their carers (as appropriate).

8.4.4 Management of patients with suspected or confirmed infectious pulmonary drug-resistant tuberculosis (DR-TB) whilst an in-patient in hospital.

Patients with suspected or known infectious DR-TB who are admitted to hospital should be cared for in a single room with negative pressure (where available) and managed with airborne isolation (and with relevant transmission based precautions signage, **see Appendix 1**) in accordance with recommendations for patients with infectious pulmonary TB. Patients with suspected or known infectious DR-TB will be under the care of a specialist team and provided with the specialist advice regarding their care. Patients are encouraged to adhere to advice given and to simple respiratory hygiene measures such as covering their mouth during coughing, hand hygiene and safe and prompt disposal of tissues where necessary. Refer to the relevant chapter on **Drug-resistant TB** for further advice.

As in the management of infectious pulmonary TB, staff should wear an FFP3 respirator mask for which they have been appropriately fit tested, and this should be fit checked as usual procedures before contact with the patient who has suspected or known DR-TB whilst they are considered infectious.

For patients where DR-TB is diagnosed or is being considered, aerosol generating procedures such as bronchoscopy, sputum induction or other aerosol generating procedures as outlined above, should be carried out in an appropriate engineered and ventilated area (a negative pressure room).

Please contact the IPC team for further advice on additional safeguards that may be required. If patients are otherwise fit for discharge and would comply with, and be able to accommodate, home isolation then early discharge could be considered. If patients have confirmed DR-TB but do not have a productive cough and have clinically improved, then a decision for discharge if thought appropriate should be taken in consultation with the relevant clinical team and Public Health team. The IPC team must be informed of the decision made.

8.4.5 Aerosol generating procedures

Sputum induction is used to obtain sputum when patients are unable to expectorate a specimen. The procedure uses sterile water or hypertonic saline to irritate the airway, increase secretions, promote coughing, and produce a specimen.

Sputum induction, an aerosol generating procedure, should only be performed in an airborne isolation room. This procedure must be avoided in an open bay or in an unventilated area in all wards/ departments on suspected or confirmed TB cases.

For patients diagnosed with TB or in whom TB is being considered, AGPs such as those outlined below or other aerosol generating activities, should be carried out in appropriately engineered ventilated area (ideally a negative pressure room). Advice should be sought from the clinical team and the infection prevention and control team. It is important that health and care workers wear the necessary PPE for these procedures as outlined in the NCEC National Clinical Guideline No. 30 Infection Prevention and Control and informed by a point of care risk assessment.

Examples of aerosol generating procedures include the following:

- Intubation
- Front of neck airway procedures – insertion of tracheostomy
- Cricothyroidotomy
- Tracheal extubation
- Bronchoscopy
- Positive pressure ventilation with inadequate seal
- CPR (pre intubation due to manual ventilation)
- High Frequency Oscillatory Ventilation (HFOV)
- Manual ventilation
- Open suctioning-procedure where a single-use catheter inserted into the ETT either by disconnecting the ventilator tubing or via a swivel connector
- Induction of sputum
- High flow nasal oxygen (HFNO) including AIRVO
- Non-invasive ventilation – CPAP/BiPAP

8.4.6 Management of patients with suspected or confirmed infectious pulmonary or laryngeal TB who require emergency or outpatient appointments.

Patients who require emergency or essential outpatient appointments must be cared for in a single room. The receiving department must be informed of the potential or actual infectious status. If it is not possible to nurse the patient in a single room the patient's waiting time must be kept to a minimum. This may involve prioritising their care above that of other patients. Ideally, the number and duration of visits a patient makes to an outpatient department whilst they are still infectious must be minimised as much as possible. To minimise the risk of infection, people with infectious TB should be seen at times or in places away from other patients. The patient should be offered a surgical face mask and encouraged to wear it.

8.4.6.1 Patient movement and transportation (non-acute transfers)

Limit the movement and transport of the patient to essential purposes only. If transfer or patient movement is necessary, staff should ensure that IPC precautions are maintained to minimise the risk of transmission to other patients and the contamination of environmental surfaces or equipment. Patients with suspected or confirmed TB when not in an isolation room should be supported to wear a correctly fitting surgical mask while they are being transferred to reduce the risk of transmission to others.

Movement should be limited to essential purposes.

If transfer is necessary:

- The patient must wear a correctly fitting surgical mask
- Receiving departments must be informed in advance
- Wating time in shared areas must be minimised.

8.4.7 Visitors

To preserve privacy and confidentiality, visiting arrangements should be discussed with the patient.

Each hospital should have a system in place to:

- Inform visitors of required IPC precautions – and need to check with ward nursing staff regarding these
- Provide guidance on hand hygiene
- Provide respiratory protection where required e.g. such as support with wearing a respirator mask and other requirements, as necessary, before and after visiting a patient with TB. Links to supporting information leaflets and resources are available in **Appendix 1**.

Visiting arrangements should balance IPC requirements with patient wellbeing.

For infants and children use airborne precautions until active infectious pulmonary TB ruled out in visiting family members.

8.4.8 Patient's needs

The purpose of IPC is to support people's access to appropriate care that is clean and safe. Effective IPC is central to providing high quality, person-centred healthcare.

Placing people who use healthcare services at the centre of IPC and enabling them to participate in the care process is not just about explaining the risks associated with treatments. It requires consideration of the person's needs at every stage of care. This must be balanced with the responsibility to maintain a safe environment for all service users and staff, minimising the risk of infection transmission.

Steps should be taken to reduce the psychological impact of prolonged isolation. Patients should have access to appropriate resources and communication tools to stay connected with others. Where clinically appropriate and safe, arrangements should be made to allow access to fresh air, including supervised outdoor walks if necessary. When planning and delivering care, particular attention must be given to the potential impact of isolation, loneliness, and separation from family and community on a patient's overall wellbeing.

8.4.9 Education of patients/ family/ carers

Clear, accessible communication is essential when providing education to patients, families and carers. Information should be provided in plain language that is easy to understand, avoiding medical jargon wherever possible. Materials must be culturally appropriate and meet the needs of diverse communities.

Written information such as an information leaflet, should include practical advice on respiratory hygiene, including:

- cough etiquette (covering the mouth and nose when coughing or sneezing, either with a tissue or coughing/sneezing into the elbow),
- the safe disposal of used tissues immediately afterwards
- the importance of hand hygiene after coughing/ sneezing, and
- wearing a mask when advised.

If a patient is advised to wear a mask, they should receive clear instructions on how to use it correctly. This includes changing the mask if it becomes wet, heavily soiled or torn.

Patients should be provided with an adequate supply of tissues and access to a suitable waste bin for safe disposal of used tissues.

Information should be available in relevant languages, and translated materials should be provided where needed. Access to professional interpretation services should also be arranged to ensure patients and families fully understand the information and can participate in care decisions.

In common areas, such as waiting rooms and corridors, consider **posters and signs** to remind people of proper cough etiquette and respiratory hygiene. See *Cover your cough and sneeze* posters (**Respiratory Hygiene Posters**) on the HSPC website. Provide tissues, surgical masks, Alcohol-based hand rubs that meet the requirements of European Standard EN 1500 should be used for routine hand hygiene practices. Waste bins should be available in common areas, such as waiting rooms, so people with respiratory symptoms can adhere to respiratory precautions (contain coughing & sneezing, perform hand hygiene and safely dispose of tissues etc.).

8.5 Non acute and non-healthcare settings

8.5.1 Management of patients with suspected or confirmed infectious pulmonary TB and their care outside acute hospital settings

Patients should be considered for discharge or managed at home if they are medically fit and do not have a continuing clinical or public health need for admission with infectious pulmonary TB and do not have risks factors for Multidrug resistant TB (MDR-TB).

If patients are discharged, they should be advised to avoid congregate settings for the first 2 weeks of their treatment for drug-sensitive TB infection. Consideration should be given to the appropriateness of discharge to a care home or other communal setting if they have not completed 2 weeks of treatment.

Unless there is clear clinical or public health need, such as homelessness, people with suspected or confirmed infectious pulmonary TB should not be admitted to hospital for diagnostic tests or for care. **Patients with drug-sensitive infectious pulmonary tuberculosis disease** should avoid all **congregate settings**—including multiple-occupancy accommodation, hostels, educational and childcare facilities, and **prisons or other places of detention**—for the first **2 weeks of effective treatment**, consistent with WHO evidence that infectiousness declines significantly after initiation of appropriate therapy and clinical improvement.

For individuals **originating from congregate settings** such as prisons, IPAS facilities or homeless hostels, it is expected that they will **remain in the acute hospital setting during this initial onboarding period of treatment**, **as part of the clinical care pathway**, rather than due to environmental risk alone. This allows for initiation of effective therapy, monitoring for response, and assurance of adherence during the period of greatest infectiousness.

Where necessary, consideration should be given (where appropriate), when no other alternative options are available, for the use of isolation facilities at the National Infectious Disease Isolation Facility (NIDIF) may be considered. This should be explored collaboratively and proportionately.

8.5.2 Prisons and Places of Detention (PPD)

Because **prisons are themselves congregate settings**, complete avoidance of shared spaces is often not possible. In these situations, a **local risk assessment** must be conducted

by the prison healthcare team in collaboration with public health. Appropriate mitigation measures may include:

- Isolation within the facility wherever operationally feasible
- Enhanced ventilation
- Respiratory hygiene measures
- Prompt initiation and monitoring of treatment
- Respiratory protection where required

8.5.2.1 Public Health Oversight and Alternative Accommodation

Local public health teams should assess all individuals diagnosed with **TB disease**—including those in prisons, immigration reception or IPAS settings, and other places of detention. Where clinically appropriate and operationally feasible, and where security conditions allow, **alternative accommodation** may be considered to reduce exposure risk to others. In prisons, specific considerations may apply depending on the custodial requirements and this is a decision for the prison governor on advice from public health and the Irish Prison Service Infection Control Team.

8.5.2.2 Ongoing Vigilance in All Congregate Settings

Even after the initial 2-week onboarding period—once the individual with **TB disease** is expected to be significantly less infectious—**continued vigilance remains essential** in all congregate environments such as:

- Prisons and places of detention
- IPAS accommodation
- Homeless hostels
- Other institutional or shared-living settings

This approach reflects the updated global understanding of the **TB spectrum**, distinguishing **TB infection** (asymptomatic and non-infectious) from **TB disease** (symptomatic and potentially infectious), and aligns with the terminology standardisation promoted through the new **Global TB Dictionary**.

In prisons and places of detention (PPD), transmission-based precautions should be implemented, and remain in place only while the person is considered infectious. These precautions are intended to prevent transmission between residents and staff.

Decisions to step down transmission-based precautions should only be made following review, and in consultation with the IPC team for the Irish Prison Service, the treating clinician, and if necessary, the relevant regional Department of Public Health.

8.5.2.3 Practical advice for patients and households

Important considerations in non-healthcare congregate settings accommodating large numbers of people and people that may have a higher risk of being exposed to TB infection or of developing TB disease, include:

- Promoting and strongly encouraging recommended hand and simple respiratory hygiene practices among staff and residents
- Ensuring awareness of symptoms of potentially infectious TB to enable prompt healthcare referral
- Ensuring adequate ventilation/ airflow
- Liaising with the local public health team to promptly manage and appropriately accommodate people with TB

People receiving outside care hospital, and living in these settings, should be supported with clear, practical advice:

- Promote simple respiratory hygiene: cough etiquette (covering the mouth and nose when coughing or sneezing, either with a tissue or coughing/sneezing into the elbow); dispose of tissues in normal household waste immediately after use; perform hand hygiene after coughing or sneezing
- Standard cleaning and disinfection practices are sufficient
- Waste can be disposed of through normal waste streams
- Bed linen in a person's home should be placed directly into the washing machine and washed on the hottest temperature suitable for the fabric
- If staff are visiting a person with known active infectious pulmonary TB for a reason unrelated to TB care, they should seek advice from the clinical team in advance of scheduling a visit.

Individual advice regarding socialising, working, or receiving visitors should be sought from the patient's clinical team. Standard cleaning and disinfection practices are recommended. Disposal of waste is as per the normal waste streams.

Patients should be encouraged to minimise aerosol production by covering their mouth and nose when coughing with tissues and advised to discard immediately and as per normal domestic waste. The patient should then be encouraged to wash their hands. Bed linen in a

patient's own home should be placed directly into the washing machine and washed on the hottest temperature the fabric will allow.

Staff should ensure that effective hand and respiratory hygiene recommendations are adhered to at all times. Further advice should be sought from the local IPC treating clinician/ Public Health teams, if required.

Refer to **Chapter 10:** Adherence, Treatment Completion and Follow-up for further advice
Refer to relevant guidance, such as **Infection Prevention and Control (IPC) Guidance for Non-Healthcare Congregate Settings (Including Homelessness and Substance Use Service Settings),** also see **Appendix 1** for useful resources.

8.6 References

1. Department of Health (2023) *National Clinical Guideline No. 30 – Infection Prevention and Control (IPC)*. Available at: **https://www.gov.ie/IPCclinicalguideline/** (Accessed: 26 November 2025).

2. Centres for Disease Control and Prevention (CDC) *Tuberculosis Risk Assessment for Health Care Facilities,* December 15, 2023 Available **https://www.cdc.gov/tb-healthcare-settings/hcp/facility-risk-assessment/index.html** (Accessed: 20 November 2025).

3. World Health Organization (WHO) *Global Tuberculosis Report* 2024. 2024. Available **https://iris.who.int/bitstream/handle/10665/379339/9789240101531eng.pdf?sequence=1.** (Accessed: 20 November 2025).

4. World Health Organisation (WHO) *TB KNOWLEDGE SHARING PLATFORM Operational Handbooks, Module 1: Prevention, Module 1: Infection prevention and control, Annexes, Annex 2. Facility tuberculosis risk assessment tool.* Available **https://tbksp.who.int/en/node/2596** (Accessed: 20 November 2025).

5. UK Health Security Agency (UKHSA) *Guidance, Management of tuberculosis in secure settings in England* Updated 9 October 2025 Available **https://www.gov.uk/government/publications/managing-tuberculosis-tb-in-prisons/management-of-tuberculosis-in-secure-settings-in-england#infection-prevention-and-control** (Accessed: 26 November 2025).

6. UK Health Security Agency (UKHSA) *Tuberculosis (TB): migrant health guide Advice and guidance on the health needs of migrant patients for healthcare practitioners.* Published 31 July 2014, Last updated 31 March 2025 Available **https://www.gov.uk/guidance/tuberculosis-tb-migrant-health-guide#prevention-and-control** (Accessed: 20 November 2025).

7. National Institute for Health and Care Excellence (NICE) *Tuberculosis guideline*, Published: 13 January 2016, Last updated: 16 February 2024 Available **https://www.nice.org.uk/guidance/ng33/chapter/Recommendations#infection-control**

Appendix1, Useful resources

National Clinical Guideline No. 30 resources:

National Clinical Guideline No. 30 resources:		
Item	**Volume No.**	**Section/ Page reference**
Individual elements of Standard Precautions.	Volume 1,	Sections 2.1.5 Page 20 Section 3.1 Page 37-87
Summary of recommendations for airborne precautions	Volume 1	Table 2 Page 4
Airborne precautions & Good practice point: 10	Volume 1 Volume 1	Section 3.2.4 page 98 Page 102.
Use of personal protective equipment for standard and transmission-based precautions (to guide selection of PPE)	Volume 1	Section 3.3 Page 103-112
Use of personal protective equipment for standard and transmission-based precautions (to guide selection of PPE)	Volume 2	Table 42 page 250
transmission-based precautions for Tuberculosis	Volume 2	Table 44 page 273
Risk-management: Case study for Mycobacterium tuberculosis	Volume 2	Section 7.7.7 Page 286-287.
Risk-management: Case study for M. tuberculosis among immunocompromised patients attending outpatient services	Volume 2,	Section 7.7.8. Page 288

Other AMRIC Guidance:

HSE AMRIC Guideline: Guide to prioritisation of patients for single room isolation when there are not sufficient single rooms for all patients that require Isolation.

- **V3.0 Guidance on Balancing Competing Demands in Relation to Restrictions on Bed Use Related to Infection Prevention and Control in Acute Hospital settings.**
- **Infection prevention and control recommendations for the use of PPE.**

AMRIC Poster Resources:

Poster resources are available on this link:

https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/

Information on PCRA, and how to use a PCRA:

- **https://www.hse.ie/eng/about/who/healthwellbeing/our-priorityprogrammes/hcai/resources/general/how-to-use-a-point-of-care-risk-assessmentpcra-for-infection-prevention-and-control-copy.pdf**
- Poster resources are available on the **"Safe use of FFP2 respirator mask" https://www.hpsc.ie/az/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/**
- Transmission based precautions posters are available on: **https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/**

- All poster resources are available on these links:
  https://www.hpsc.ie/publications/posters/
  and
  https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/

AMRIC E-Learning resources:

- A suite of AMRIC e-learning resources can be accessed via the **AMRIC Hub** at **https://www.hseland.ie**
- The following AMRIC training resources may be helpful in relation to this guidance:

- AMRIC Hand Hygiene
- AMRIC Standard and Transmission-Based Precautions
- AMRIC Personal Protective Equipment
- AMRIC Healthcare-Associated Infections (HCAI): An Overview for Managers
- AMRIC Outbreak – Prevention and Management
- AMRIC Respiratory Hygiene and Cough Etiquette
- AMRIC Routine Management of the Physical Environment
- AMRIC IPC Risk Assessment

Patient information leaflets:

Supporting information leaflets and HCAI resources are available on the HSE website: **https://www.hse.ie/**

Other resources

In addition, the below resources may be helpful when referred to alongside this guidance:

- UK Health Security Agency (UKHSA) Guidance: **Risk of Infectious Disease Transmission Posed by Communal Accommodation.**
- Public Health guidance on prevention and control of infectious diseases in communal settings for displaced people fleeing war in Ukraine **[English]**
- Guidance on the Minimum Hygiene and Public Health Standards required in communal centres used to temporarily shelter persons displaced from war in Ukraine **[English]**
- Hand Hygiene poster **[English] [Ukrainian] [Russian]**
- Poster on healthcare risk waste. Available online **here.**
- A number of disease-specific resources, including information leaflets and factsheets, can be found on the HPSC website: **https://www.hpsc.ie/**
- Plain language resources are available: **https://healthservice.hse.ie/staff/procedures-guidelines/plain-language-guidelines/**