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Public Health Wales (Health Protection)

# Infection Prevention and Control (IP&C) Measures for Suspected and Confirmed Cases of Mpox in Healthcare Settings in Wales

## PHW-MPOX-GUI-Version 3 (Wales)

# Infection Prevention and Control (IP&C) measures for suspected and confirmed cases of Mpox (previously known as monkeypox) in healthcare settings in Wales.

| Version | Date | Amendments |
|---|---|---|
| PHW-MPOX-GUI-001- V3.0 (W) | 20/03/2025 | Updated in response to ACDP derogation of **Clade I** (Ia &Ib) as non-HCID |
| V2.2 (W) | 11/11/2024 | Amended advice for Mpox vaccination teams |
| V2.1(W) | 30/09/2024 | The classification and IP&C pathways have been updated in Appendix 1. |
| V2.0(W) | 18/09/2024 | Updated in response to the outbreak of HCID (**Clade I**) Mpox in the African Region, declared a public health emergency of international concern by the World Health Organization: Update to HCID case definition and use HCID PPE |
| V1.10(W) | 23/08/2023 | Modified to take into account HCID status removed from travelers to West Africa. |
| V1.9(W) | 05.06.2023 | The classification and IP&C pathways have been updated along with an addition of Appendix 1. |
| V1.8(W) | 06.07.2022 | Reference to DFT Multilateral Agreement added M347 |
| V1.7(W) | 29.06.2022 | Modified to take account of HCID derogation statement UKHSA |
| V1.6(W) | 06.06.2022 | Table 1 modified align with Principles document. Amended for use in Wales with appropriate links to Welsh specific guidance. |
| V1.5 | 30.05.2022 | Final version – amended to include visor/eye protection in table 1 if risk of spraying or splashing |
| V1.4 | 28.05.2022 | additional context on High Consequence Infectious Disease (HCID) classification following update of UKHSA principles for mpox control in England |
| V1.3 | 27.05.2022 | comments from regional leads and DAs |
| V1.2 | 27.05.2022 | Changes to PPE based on UKHSA principles for mpox control in England and DA discussions |
| V1.1 | 26.05.2022 | Minor corrections (abbreviations in full etc.) prior to publication |
| V1.0 | | Final version (HSE, occupational medicine, regional leads including ambulance IPC lead, devolved administration IPC leads, and wider service comments) |
| V0.2 | 24.05.2022 | Regional leads comments |
| V0.1 | 23.05.2022 | First draft (NHSEI) |

Acknowledgement: Amended for use in Wales from original document prepared by NHSE/NHS Scotland IP&C team in conjunction with Devolved Administrations.

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| Public Health Wales Health Protection Guidance |
| **Document Title:**<br>Infection Prevention and Control (IP&C) measures for suspected and confirmed cases of Mpox (previously known as monkeypox) in healthcare settings in Wales |
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| **Purpose and Summary of Document:**<br>To provide infection prevention and control (IPC) measures to prevent transmission of Mpox (MPX) in health and care settings in Wales. |
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| **This document is uncontrolled when printed.** |

## Contents

## 1. Introduction

General information on Mpox including case definitions, clinical pathways and contact tracing is based on the UK Health Security Agency (UKHSA) guidance and distinguishes actions for all strains.

The purpose of this document is to provide infection prevention and control (IPC) measures to prevent transmission of Mpox (MPX) in health and care settings in Wales. The guidance is based on the published Mpox Principles for control of non HCID mpox in the UK: 4 nations consensus statement and from the UK Health Security Agency (UKHSA) and associated UKHSA Mpox guidance collection. This document should be read in conjunction with the NIPCM - Public Health Wales (NHS. Wales) specifically appendix 11.

On 19th February, 2025 a letter was issued by Advisory Committee on Dangerous Pathogens (ACDP) to UKHSA recommending derogating **Clade I (a&b)** as non HCID alongside Clade II. This is described in the derogation of **Clade I** published 19th March 2025 as agreed by the CMOs of the 4 nations. These changes are being communicated in Wales via a CMO alert and Public Health Wales Briefing note.

This document should be used by organisations and employers to support local implementation/risk assessment to ensure appropriate application across the health system.

**Unless otherwise specified in this document, the guidance below applies to all current Mpox Clades and subclades as non-HCID Mpox.**

All health and care staff must be familiar with the principles of standard infection control precautions (SICPs) and transmission-based precautions (TBPs) for preventing the spread of infection in health and care settings. NIPCM - Public Health Wales (nhs.wales).

## 2. General Information and Background

There are two known clades of Mpox Virus (MPXV) of the nomenclature: **Clade I** (a & b) and **Clade II (a&b). As of 19th March 2025, Clade I (a&b) have now been derogated** by ACDP/UKHSA as **non-HCID alongside Clade II**. The term Mpox is now used rather than Monkeypox (term used in the 2022 incident) for the two known clades. **Mpox is a viral zoonotic disease.**

**The first case of Clade I MPXV** was identified in the United Kingdom (UK) in October 2024 with a total of 10 identified to date associated with travel to the affected countries or as close contacts of the index case (correct 23rd February 2025). Overall risk of Clade I MPXV to the UK population is still considered low to medium. However, given the ongoing outbreaks abroad, it is important to remain alert to cases that have a link to specified countries or with an unusual presentation.

Between 25 July and January 2025, confirmed **Clade I (a and/or b)** MPXV cases have been reported from a number of African countries and the Democratic Republic of Congo including Burundi, Tanzania, Kenya, Rwanda and Uganda, Cameroon, which has expanded the geographical footprint of **Clade I** MPXV in the African Region. A small number of cases have also been confirmed outside of these countries associated with travel including UK, Germany, Ireland, Sweden, United states of America, United Arab Emirates and Thailand. The WHO provides a dashboard on global mpox trends.

In the UK Mpox **Clade I** remains of interest in healthcare settings but has been derogated for Infection Prevention and Control (IPC) purposes and precautions (see table 1). **While the primary mode of transmission is believed to be via touch, droplets, and fomites it was listed initially in August 2024 as a HCID due to droplets and uncertainty about potential transmission routes for this clade.** Infection with **Clade Ia** MPVX has been reported to cause more severe Mpox disease with a higher case fatality in affected countries though ACDP recognises the available data on severity is not translatable to healthcare systems in the UK.

There is, however, evidence from case management in the UK that there is low severity of disease from Clade Ib. Hence recommending Clade I and all subclades (in terms of pathway and IPC) to be managed the same as Clade II i.e. both non HCID.

**This should not be interpreted as Mpox no longer being of any public health consequence; the disease is still a public health emergency of international concern as defined by WHO. This concern should be reinforced in messaging to healthcare workers and staff managing suspected and confirmed cases.**

**Clade II MPXV**, not currently of concern, caused community outbreaks of MPXV infections in the UK in 2022 with cases still being detected across UK. The Advisory Committee on Dangerous Pathogens (ACDP) advice published by UKHSA 5th July 2022 recommended that the West African Clade MPXV Clade II (Lineage B.1 y) should not be classified as a HCID. This status remains unchanged but where individuals with infection who have evidence of lower respiratory tract involvement or severe systemic illness requiring hospitalisation, the possibility of airborne transmission has not been excluded.

The ACDP committee has advised that disease caused by new future clades of Mpox would only be considered as HCID if there were signals of specific concern.

## 2.1. Infectious period

The incubation period is the duration/time between contact with the infected person and the time that the first symptoms appear.

**The incubation period for both Clades of Mpox is between 5 and 21 days, usually 6 to 16 days.**

**An individual is contagious until all the scabs have fallen off and there is intact skin underneath generally 6-14 days. The scabs may also contain infectious virus material.**

## 2.2. Symptoms

The incubation period is the duration/time between contact with the infected person and the time that the first symptoms appear. The incubation period for Mpox **both Clades of Mpox** is between 5 and 21 days, usually 6 to 16 days. The illness begins with:

- Fever
- Headache
- Muscle aches
- Backache
- Swollen lymph nodes
- Chills
- Exhaustion
- Joint pain

However, not all people who have Mpox experience all of these symptoms.

Within 1 to 5 days after the appearance of fever, a rash develops, often beginning on the face then spreading to other parts of the body, including the genitals. The rash changes and goes through different stages before finally forming a scab which later falls off. Some individuals may not have a widespread rash, and in some cases only genital lesions are present. These may be blisters/vesicles, scabs or ulcers.

## 2.3. Transmission

Transmission of Mpox to humans can be due to zoonotic transmission or person-to-person spread. Transmission of Mpox may occur through close contact with an infectious individual (direct) or contaminated fomites such as clothing and bed linen (indirect), and respiratory droplets.

Person-to-person spread may occur through:

- Direct contact with skin lesions or scabs (including during physical or sexual contact, kissing, cuddling or other skin-to-skin contact).
- Coughing or sneezing of someone who has Mpox when they’re close to you.
- Contact with clothing or linens (such as bedding or towels) used by someone with Mpox.

Areas with heavy exposure to the virus, such as exposed skin and exposed mucosal surfaces may have more numerous and severe lesions. Sexual transmission of Mpox can lead to lesions concentrated in areas involved in sexual activity, including the genitals, the perianal area, rectum, and oral cavity (mouth and throat). Deroofing procedures and throat swabs are not considered to be aerosol generating procedures (AGPs) but may cause droplets.

Spread of Mpox may also occur when a person comes into close contact with an infected animal (rodents are believed to be the primary animal reservoir for transmission to humans), human, or materials contaminated with the virus. **Mpox has not been detected in animals in the UK**.

## 3. Patient management

**It is important that IPC precautions and pathways are employed for any suspected Mpox case (Clade I or II) while investigations against definitions are undertaken.** Transmission Based precautions (TBP's) will be applied (see Table 1 & Appendix 1) until investigations are complete and Mpox is no longer suspected Or if suspected but testing then confirms it is not a Mpox diagnosis Or TBP's are required for another infectious risk e.g. chicken pox, measles (NIPCM - Public Health Wales (nhs.wales)).

### 3.1. Case definitions

Additional details on Mpox clinical features can be found at Mpox: background information.

Consider Mpox where a case presents with:

1. A prodrome (fever, chills, headache, exhaustion, myalgia, arthralgia, backache, lymphadenopathy) in an individual with contact with a confirmed or suspected case of Mpox in the 21 days before symptom onset

   Or:

2. An Mpox-compatible rash anywhere on the skin (face, limbs, extremities, torso) or mucosae (including oral, genital, anal), or symptoms of proctitis, and at least one of the following in the 21 days before symptom onset:

   a. Recent new sexual partner.

   b. Contact with known or suspected case of mpox.

   c. A travel history to a country where mpox is currently common - this does not include people transiting through the affected country where they do not leave the airport.

   d. Link to an infected animal or meat.

Or:

3. An Mpox-compatible rash anywhere on the skin (face, limbs, extremities, torso) or mucosae (including oral, genital, anal), or symptoms of proctitis, where there is no risk factor and no alternative common differential diagnosis [note 1]. These patients should be discussed with local infection services to determine the approach to investigation and management.

Note 1: alternative common differential infections include varicella zoster virus (which causes chickenpox or shingles), herpes simplex virus, and enterovirus (which causes hand, foot and mouth disease), and bacteria such as staphylococcal and streptococcal infections.

UKHSA's Mpox resource collection will be kept up to date to assist NHS clinicians in diagnosis.

## 4. Risk assessment and management (Hierarchy of Controls (HoC))

Risk assessments must be carried out in all areas where Mpox suspected or confirmed cases may present/are cared for. This should be undertaken by a competent person(s) with the skills, knowledge, and experience to be able to recognise the hazards associated with MPXV and establish the necessary IPC controls required should a case present. On completion this risk assessment needs to be communicated to all relevant staff. This can be used to populate local risk management systems.

Posters and patient information should be displayed at entry points and reception areas e.g., Emergency Departments, Minor Injury Units, GP's surgery to raise patient awareness of the need to alert staff immediately on arrival of any suspected risk of Mpox.

Staff at reception points should have a heightened awareness of Mpox and associated definitions especially travel history when booking in patients to ensure they can rapidly inform clinical staff so that triage and isolation is expedited without delays.

Application of the hierarchy of control measures can be used to help implement effective controls and reduce the spread of MPXV in healthcare settings. These are considered in order, including elimination, substitution, engineering, administrative controls and PPE/RPE, and the appropriate control measures identified. Safe systems of work determined in this way are an integral part of IPC measures.

Some of the key areas and measures that could be considered are:

- Elimination (physically remove the hazard) e.g., efforts should be made to perform telephone triage/assessment to help establish symptoms present and risk associated with potential Mpox in advance of any face-to-face contact where suspected. Substitute in-person assessment/treatment if clinically appropriate by the use of virtual consultations (telephone or video).

- Substitution (replace the hazard), this may not be achievable in all healthcare settings, as above consider virtual consultation in primary/outpatient care.

- Engineering (control, mitigate, or isolate people from the hazard) e.g., ensuring ventilation systems meet national recommendations for minimum air changes in areas where suspected or confirmed Mpox cases are cared for.
- Vaccination in line with national guidance.
- Administration (safe systems of working) e.g. adequate training in IPC control measures below are implemented effectively.
- Personal protective equipment (PPE) e.g., ensure adequate supply and availability of appropriate PPE including RPE (including Fit Testing) to protect staff.

## 5. Triaging (assessment of infection risk), patient placement and testing

UKHSA guidance on Mpox is available to support triage.

Staff should be aware that any patients presenting with fever and rash may be infectious (e.g., measles, varicella zoster virus) and must take immediate action to prevent further transmission.

If an individual arrives at any healthcare facility for treatment of an unexplained rash or symptoms/ history consistent with suspected Mpox they should also immediately be isolated and triaged and managed with TBP's until assessed by the clinician. This includes individuals seeking treatment for another condition but with an unexplained rash or symptoms/ history consistent with suspected Mpox. In both cases PPE is required as outlined in table 1.

If Mpox is then suspected, after discussion with the individual, clinicians should contact their local consultant medical microbiologist/ID physician for further advice as outlined above.

The consultant medical microbiologist/ID physician will direct where the patient should be safely cared following clinical risk assessment of symptoms and against case definitions and direct how samples will be obtained.

Triaging and testing should be undertaken by clinical staff who are trained and competent in the application of clinical case definitions/testing for Mpox in a suitable designated area. Following this assessment, the patient may require transfer to another setting e.g., negative pressure isolation, ID unit or suitable environment where they can be managed safely for the duration of their stay.

If Mpox infection is suspected from initial case investigation in secondary care, the patient should be isolated in a negative-pressure single room with dedicated medical and patient care equipment or as a minimum a single room with ensuite facilities separated from vulnerable patients. Inform the local Infection Prevention and Control team without delay.

Heath Board/Trust policies for any infectious patient should already identify the patient pathway (not just for Mpox) and include the isolation and placement of a suspected case and accessing of appropriate PPE.

Where there are minimal numbers of negatively pressurised rooms, these should be prioritised for suspected or confirmed Mpox **Clade I** cases. Suspected or confirmed Mpox cases will now all be managed as a non-HCID requiring TBP's and (risk assessed) airborne personal protective equipment (PPE) until Clade and subclade is known or tested negative. Positive pressure single rooms **must not be used**. The guidance on provision of negative pressure isolation is can be found in WHBN 04-01 (supplement 2) Negative Pressure Suites: Technical Guidance in support of Welsh Health Circular WHC (2018) 033 Airborne Isolation Room.

Where clinically appropriate, individuals with suspected or confirmed Mpox should be offered a virtual or telephone consultation. If the patient has presented in person in a community setting or to a GP surgery without prior consultation, if on initial investigation or interview Mpox is

suspected the patient should be isolated in a room on their own with the door closed (ideally with access to a phone) and IPC controls applied until advice has been sought.

**Firstly,** seek advice from a PHW Consultant Microbiologist/ID physician to discuss and risk assess the suspected case and guide the actions required. **Secondly**, after risk assessment suspected cases should be notified to PHW health protection team (0300 003 0032) via AWARe.

Anyone with suspected Mpox requiring face-to-face clinical review should be advised to use their own private transport if available and providing this will not result in exposure of previously unexposed individuals. If private transportation is unavailable, individual advice on the use of public transport may be provided depending on patient symptoms and history e.g., respiratory symptoms, lesions and if these can be covered, likelihood of **Clade I** or **Clade II** suspected based on UKHSA definitions. Should a suspected Mpox patient be too unwell to travel independently, the ambulance service should be informed. In an emergency situation the 999-call handler must be informed that Mpox is suspected.

## 6. Notification

The clinician in charge of the patient should urgently discuss any patient with suspected Mpox and severe or disseminated disease with their local Medical Microbiologist/ID physician who are in a position, and have the resource, to advise the clinicians responsible for the patient even if no travel history is identified. It is for the Microbiologist/ID clinician to discuss further with the Imported Fever Service (IFS)) as necessary.

AND THEN

Notify the PHW Health Protection Team (0300 003 0032) via AWARe urgently on suspicion of Mpox and to discuss the classification of contacts.

## 6.1. Specimen handling

MPXV is a Hazard Group 3 organism (ACDP/HSE), Separate guidance on specimen type, handling and shipment requirements have been sent to laboratory networks in Wales. Specimens will only be sent after the case has been discussed and on direction of the consultant Microbiologist. Specimens from Wales will be tested through the virology department at the University Hospital of Wales, Cardiff for Mpox. In addition, microbiology will liaise with the Rare and Imported Pathogens Laboratory (RIPL): on specimen referral. Anyone handling specimens prior to laboratory transfer should adopt the PPE requirements set out in this guidance, as a minimum.

# 7. Infection prevention and control measures

## 7.1. Source control

All suspected and confirmed cases of Mpox should be provided with a facemask (type II or type IIR) on arrival at the care area in all healthcare settings to be worn for the duration of the treatment/consultation unless removed for clinical assessment/treatment. Those accompanying

the patient (e.g., family/carer/guardian/partner) should also be provided with a facemask if they have any of the prodromal symptoms i.e.:

- Fever
- Headache
- Muscle aches
- Backache
- Swollen lymph nodes
- Chills
- Exhaustion
- Joint pain

However, not all people who have Mpox experience all of these symptoms.

Facemasks are not required to be worn by inpatients in a single room/isolation room where IPC precautions are in place. Patients with suspected or confirmed Mpox transferring from one care area to another should wear a facemask (unless clinically contraindicated).

The requirement for patients to wear a facemask must never compromise their clinical care, such as requirement for oxygen therapy, causing respiratory or other type of distress e.g., in paediatric patients, respiratory diseases, those with additional learning needs, phobias etc.

Where clinically appropriate, before attending or upon arrival at the healthcare setting, advise individuals with clinically suspected Mpox to cover any external lesions.

Lesions should remain covered during transfer between care areas and until clinical assessment.

## 7.2. Personal protective equipment in all healthcare settings

The requirement and level of PPE depends on the application of workplace assessments based on the Hierarchy of Controls as above (section 4). For any individual presenting in person for advice/treatment, an infection risk assessment requires clinical judgement to identify the risk of cross transmission, and the PPE required.

Consideration also needs to be given to the operational definition of the presenting case of Mpox as outlined in UKHSA Derogation of Clade I Mpox guidance:

PPE requirements will differ based on:

- The operational definition above and hence whether or not the case is considered an Mpox or has a differential diagnosis presenting with rash.
- The individual's presenting symptoms (if they present with an unexplained rash or other symptoms resulting in a clinical suspicion of Mpox and have not been triaged).
- Whether or not respiratory symptoms / disseminated lesions or a deteriorating condition are present.
- The clinical procedures being undertaken e.g., prolonged clinical and close contact.

Table 1: Minimum PPE requirements for suspected and confirmed Mpox cases

| Minimum PPE required for: | PPE required |
|---|---|
| Where an individual with clinically suspected Mpox presents in person at a primary care, community or outpatient setting and requires immediate clinical care.<br><br>In acute settings (physical and mental health) for triage and assessment of suspected cases against the Mpox operational case definition. | Droplet PPE:[1,3.]<br><br>• Gloves – single pair.<br><br>• Fluid Resistant Surgical Facemask (FRSM – Type IIR).<br><br>• An apron (or disposable, long-sleeved, fluid-resistant gown where extensive manual handling or unavoidable skin-to-skin contact is anticipated).<br><br>a visor/eye protection (if there is a risk of spraying/splashing e.g., when sampling). |
| **Suspected or Confirmed Mpox case (Clade I or II[4])**<br><br>In acute settings where a patient with suspected Mpox has been assessed and/or admitted for clinical care while awaiting results of diagnostic testing OR confirmed and awaiting transfer to a designated treatment area.<br><br>Where symptomatology is limited to a rash and patient is generally well – NO RESPIRATORY SYMPTOMS. | Droplet PPE:[1,3.]<br><br>**PPE requires [3] :**<br>• Gloves – single pair.<br><br>• Fluid Resistant Surgical Facemask (FRSM – Type IIR).<br><br>• An apron (or disposable, long-sleeved, fluid-resistant gown where extensive manual handling or unavoidable skin-to-skin contact is anticipated).<br><br>A visor/eye protection (if there is a risk of spraying/splashing e.g., when sampling). |
| Suspected and Confirmed Mpox (Clade I & II[4])<br><br>Where symptomatology includes RESPIRATORY SYMPTOMS, widespread rash and/or clinically deteriorating as a direct result of Mpox.<br><br>AND/OR<br><br>Prolonged close contact with a patient and their environment (including extensive manual handling), for example continued inpatient care or repeated assessment of an individual who is clinically unwell or deteriorating. | **Treat as Airborne Infection.**<br><br>PPE requires[3]<br><br>• An FFP3 respirator (fit-tested and fit-checked) or equivalent e.g., powered air purifying respirator (PAPR)[2] rather than FRSM.<br><br>• Gloves – single pair<br><br>• A disposable, fluid-resistant long-sleeved gown (coveralls may be worn in some settings e.g., ambulance).<br><br>• A full-face visor.[1,2,] |

1. Please note many FFP3 respirators are not fully fluid-resistant, therefore a full-face visor is recommended.

2. PAPR are a suitable alternative to FFP3 for management of **Mpox (Clade II & Clade I) cases**. If a PAPR is used for a confirmed Mpox case, it **must be decontaminated.** Decontamination protocols must be in place for any reusable components with responsibility assigned. **Dispose of any waste as** category B waste.

3. If the patient is confirmed positive for Mpox, staff will be classed as a contact if the incorrect PPE is worn, or the PPE is worn incorrectly and/or if not Fit tested to wear an FFP3 (see contact tracing guidance).

4. The ACDP committee has advised that disease caused by new future clades of Mpox would only be considered as HCID if there were signals of specific concern.

The PPE requirements in table 1 apply to all patient care activities including triage, testing, direct clinical care, cleaning of the equipment and the environment, management of waste, linen and blood and body fluid spillages.

There is guidance for safe donning and doffing of PPE available, but Health Board/Trusts should train against the recommended ensemble and their own policy. Examples of resources that may be useful depending on ensemble required include the NIPCM appendix 6.

### Important note

The requirements for suitable and adequate PPE in the ambulance service may differ due to the settings and conditions in which they operate.

The ambulance service should continue to follow advice on TBP's (Droplet and on Airborne) PPE as set out by Welsh Ambulance Service (WAST) policies.

## 7.3. Decontamination of environment and care equipment for all healthcare settings

Only clinical staff trained and competent in PPE should enter the at-risk clinical environment for suspected or confirmed Mpox. These staff may need to perform tasks such as environmental cleaning that are typically handled by other groups so also need to be appropriately trained and competent to do so.

Equipment and stock in the room where a suspected or confirmed case of Mpox is being managed should be kept to an absolute minimum. Patient care equipment should be dedicated to the individual for a suspected or confirmed case of Mpox and wherever until a diagnosis is confirmed.

Decontamination of the environment and care equipment for a droplet or airborne infection when caring for a an infectious patient should align to the organisation's environmental cleanliness policy and the national standards of cleanliness.

The Mpox virus will be destroyed by hospital detergents and disinfectants. Decontamination of reusable patient care equipment and medical devices after use on the suspected or confirmed case should be in line with Appendix 7 of the NIPCM.

Refer to section 2.3 of the NIPCM.

### 7.3.1. Inpatient settings

Only Patient isolation rooms/area must be decontaminated at least daily; this may be increased on the advice of IPCTs.

The room should be decontaminated using either:

- A combined detergent disinfectant solution at a dilution (1,000ppm av.chlorine.); or
- A general-purpose neutral detergent in warm water followed by a solution of 1,000ppm av.cl. (or alternative locally agreed validated biocidal/virucidal cleaning product).

Increased frequency of decontamination/cleaning schedules should be incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g.:

- Toilets/commodes particularly if patients have diarrhoea.
- Frequently touched" surfaces e.g., door/toilet handles, locker tops, over bed tables and bed rails.
- General surfaces e.g. flooring, worksurfaces where there is excessive shedding from skin lesions and/or the patient has significant respiratory symptoms.

Reusable (communal) non-invasive care equipment and medical devices must be decontaminated:

- Between each patient and after patient use.
- After blood and body fluid contamination with 10,000pm av. cl (see appendix 7 of the NIPCM) or according to manufacturer guidance.
- At regular intervals as part of scheduled, routine equipment cleaning.

Vacated rooms should also be decontaminated following an Aerosol Generating Procedure (AGP). AGP List.

### 7.3.2. Post discharge/transfer clean

Advice should be sought from the IPC team on decontamination of the environment following a confirmed Mpox.

Following patient transfer, discharge of an Mpox case, or once the patient is no longer considered infectious, a 'post infection clean' (which may include an enhanced clean) to remove from the vacated isolation room/cohort area, all:

- Waste - correctly packaged, labelled and stored securely prior to collection (see 6.2).
- Bedding/bed screens/curtains (if reusable) (see 6.3).
- reusable non-invasive care equipment and medical devices (decontaminated in the room prior to removal).

Rooms must be cleaned from highest to lowest points and from least to most contaminated points.

Decontamination if a clinically suspected or confirmed Mpox case or a contact visits the setting, the following decontamination procedures should be carried out after they leave:

- Decontaminate reusable non-invasive care equipment in the room before removal (as per section 6.6).
- Remove waste (see section 6.7).
- Remove bed screens and curtains – dispose of or clean according to section 6.8 (safe management of linen) and section 6.7 (safe management of waste).

Clean and disinfect waiting areas, facilities (such as toilets), treatment or assessment areas, and any reusable equipment used. Use either:

- A combined detergent/disinfectant solution with a concentration of 1,000 parts per million (ppm) available chlorine (av.cl).

or

- A general-purpose neutral detergent in warm water followed by a disinfectant solution of 1,000ppm av.cl. (or an alternative locally agreed cleaning product).

Clean from highest to lowest points and from the least to most contaminated areas, ensuring all equipment and surfaces (including floors) are decontaminated.

### 7.3.3. Decontamination in primary care, community and outpatient settings

If a clinically suspected or confirmed Mpox case or a contact visits the setting, the following decontamination procedures should be carried out after they leave (as for 7.3.2) using the same products stated above and wearing the PPE outlined in Table 1.

Advice should be sought from the IPC team on decontamination of the environment following a confirmed Mpox

- Decontaminate reusable non-invasive care equipment in the room before removal.
- Remove waste.
- Remove bed screens and curtains.

Clean and disinfect waiting areas, facilities (such as toilets), treatment or assessment areas, and any reusable equipment used. Use either:

- A combined detergent/disinfectant solution with a concentration of 1,000 parts per million (ppm) available chlorine (av.cl).

or

- A general-purpose neutral detergent in warm water followed by a disinfectant solution of 1,000ppm av.cl. (or an alternative locally agreed cleaning product).
- Clean from highest to lowest points and from the least to most contaminated areas, ensuring all equipment and surfaces (including floors) are decontaminated. This must include all equipment and surfaces and as a minimum, a full floor clean at the end of the day.

The extent of decontamination between patients will depend on the duration of the consultation/assessment, the patients presenting symptoms, suspected Clade and any visible environmental contamination.

Equipment used for environmental decontamination must be either single-use or dedicated to the affected area then decontaminated or disposed of following use for example cloths, mop heads.

## 7.4. Primary care/outpatient settings

Individuals are advised that all non-urgent medical and dental appointments should be cancelled while under investigation or isolating at home.

As part of an investigation into confirmed Mpox cases in the UK, individuals that are identified as potential contacts of the case are contacted. These individuals are then asked to contact a Health Protection Team (HPT) if they develop compatible symptoms. However, if a patient who has been identified as a contact of a Mpox case were to present in primary care, community or outpatient settings the local HPT should be contacted for advice. Health Protection Team (HPT) will advise and follow up contacts. It is unlikely that patients with severe Mpox (Clade I or Clade II) will present to primary care services.

## 7.5. Safe management of blood and body fluids

Spillages of blood and other body fluids must be treated immediately by staff trained to undertake this safely. Responsibilities for the treatment of blood/body fluid spills must be clear within each area/care setting. Spillages must be rendered safe with 10,000ppm av. cl.

For management of blood and body fluid spillages see Appendix 9 of the NIPCM.

## 7.6. Safe management of waste

Mpox is classified by the UN and WHO as a Category A pathogen for the purpose of waste management and transport.

However, the Department for Transport Multilateral Agreement M347 under section 1.5.1 of ADR on the carriage of Mpox virus is the derogation to Category B for clinical waste and still applies to this incident (see Appendix 1).

The transport of viral cultures by the laboratory remains as Category A. Advice should be sought from your local waste managers and the local waste contractor, a Dangerous Goods Safety Adviser, or Welsh Health Technical Memorandum 07:01 'Safe Management of Healthcare Waste'.

## 7.7. Safe management of linen

Contaminated clothing and linen are a potential source of transmission.

Do not:

- Rinse, shake or sort linen on removal from beds/trolleys.

  Place used linen on the floor or any other surfaces e.g., a locker/tabletop.
- Re-handle infectious linen once bagged.
- Overfill laundry receptacles (not more than 2/3 full).

All linen/clothing generated in the care of suspected or confirmed case of Mpox (Clade I & Clade II) must be managed as infectious linen and bagged into a water soluble or soluble seam (alginate) bag then placed into a polythene bag or impermeable sack (before removal from the room) – see appendix 8 of the NIPCM and WHTM 01-04.

Ensure a laundry receptacle is available as close as possible to the point of use for immediate linen deposit.

## 8. IPC advice for ambulance services/patient transport services (PTS)

Advice outlined in this document on safe working practices apply. Ambulance services should follow WAST standard operating procedures for managing infectious individuals (including Mpox).

## 9. Visitors

Visitors to suspected or confirmed Mpox patients should be restricted. If essential, for example a carer/guardian/partner/parent, individual advice should be sought from IPC/Health Protection team. They should be kept fully appraised of the situation and aware of the necessary IPC and other precautions. Health Protection Team (HPT) will advise and follow up case contacts including information on self-isolation at home if appropriate.

## 10. Occupational health/vaccination of staff contacts of a case

Guidance on Mpox contact tracing including classification of contacts and advice for vaccination and follow up, and recommendations for the use of pre and post exposure vaccination during a Mpox incident is available from your local PHW Health Protection Team.

Risk assessment should include identification of health and care staff who may be at high risk of complications from Mpox. Employers should:

- Discuss and complete a risk assessment with employees who are at high risk for complications for Mpox, for example, those who are pregnant, or are immunocompromised. Occupational Health (OH) may be involved at a strategic level to:
    - Assist employers to devise appropriate systems for identification of staff at high risk, e.g., by self -declaration following provision of relevant information and an invitation to do so.
    - Ensure that advice is available to all health and care staff, including specific advice to those at risk from complications. This should include access to confidential OH assessment and advice. Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff.

Pregnant women should always avoid people with infective, or possibly infective, rashes. Pregnant women should not work with confirmed or probable Mpox cases. ID assessment/ treatment and isolation units should not have pregnant HCWs working in them. Pregnant workers should avoid working with suspected cases (for instance, if there is an assessment clinic organised, it should not be staffed with pregnant workers.) If there is a patient which meets or is likely to meet the case definition, pregnant workers should not have face to face contact with them. If there is a pregnant worker in a high-risk area such as GU clinic, employers should consider whether other roles are available, such as telephone work.

## 11. IPC advice for Mpox vaccination teams

The IP&C requirements are those in line with Standard IP&C vaccination protocols and there is considered no additional risk. Gloves are not routinely required for administration of the vaccination.

Vaccinating a contact of a Mpox case involves minimal contact with the individual and therefore carries a low transmission risk for infection.

The vaccination of all contacts is a planned intervention, and an initial assessment of symptoms should be made prior to the individual attending. The individual contact should be asymptomatic (not in prodrome and without rash) and as such they should not be infectious.

The vaccinator should confirm this assessment with the individual contact before proceeding with the vaccination. Should the assessment indicate that the individual contact be a suspected or confirmed case of Mpox the PPE in Table 1 applies where vaccination of a suspected or confirmed case of Mpox is required.

# Appendix 1

Mpox classification and appropriate infection prevention (IPC) pathways.

Information about the status of Mpox is available at UK Health Security Agency (UKHSA) Mpox guidance. Whether the Clade is known or not all cases meeting the operational definitions for Mpox should be managed as a non HCID case. (Numbered notes refer to the notes beneath the table.)

| **Type of Mpox: World Health Organization (WHO) designation** | **Type of Mpox: previous designation** | **Advisory Committee on Dangerous Pathogens (ACDP) Hazard Group [note 1]** | **Transportation of samples [note 2]** | **Transportation of viral cultures [note 3]** | **Categorisation of waste [note 2]** | **HCID pathway [note 4]** | **IPC measures for clinically suspected and confirmed cases of Mpox in healthcare settings [note 5)** |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| **Clade I** (Two subclades)<br>• clade Ia<br>• clade Ib | Congo Basin or Central African clade | 3 | Category B | Category A | Category B in a clinical setting.<br><br>Those isolating at home can dispose of their waste in the domestic waste stream.<br><br>Mpox: people who are isolating at home. | No | Table 1: personal protective equipment (PPE) requirements for clinically confirmed Clade I (Ia & Ib) confirmed/suspected clade II Mpox<br><br>note 6] NIPCM Wales Appendix 11, (*'Aide memoire for patient placement considerations and respiratory protective equipment (RPE) )* |
| **Clade II**<br>Two subclades:<br>• Clade IIa<br>• Clade IIb [note 7] | West African clade | 3 | Category B | Category A | Category B in a clinical setting.<br><br>Those isolating at home can dispose of their waste in the domestic waste stream.<br><br>Mpox: people who are isolating at home. | No | Table 1: personal protective equipment (PPE) requirements for clinically suspected and confirmed clade II mpox |

**Notes**
[note 1] See The Approved List of biological agents – MISC208 (hse.gov.uk) Advisory Committee on Dangerous Pathogens and Health and Safety Executive (HSE).
[note 2] See Multilateral agreement M347 under section 1.5.1 of ADR on the carriage of monkeypox virus. By derogation of paragraph 2.2.62.1.4.1, Section 3.2.1. (Table A, 'Dangerous goods list') and Chapter 4.1 of 'Accord relatif au transport international des marchandises dangereuses par route'
ADR), infectious substances containing mpox virus except for cultures of mpox virus may be carried under UN 3373 or UN 3291, as appropriate.
[note 3] Laboratory cultures of MPXV (any clade or lineage) will continue to be assigned to Category A. These will be carried under UN 2814 and packing instruction P620
[note 4] See High consequence infectious diseases (HCID).
[note 5] Mpox Link to Resources Public Health Wales
[note 6] See NIPCM – Public Health Wales.
[note 7] Variants from the Clade IIb, B.1 lineage were the cause of most cases during the 2022 global outbreak.

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