ARHAI Scotland
Antimicrobial Resistance and Healthcare Associated Infection

NHS National Services Scotland

Infection Prevention and Control advice for healthcare settings:

Monkeypox (Monkeypox (Clade IIb) only): Management of possible, probable, and confirmed cases

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Disclaimer: When an organisation e.g. a health and care setting uses products or adopts practices that differ from those stated in this National Infection Prevention and Control Manual, that individual organisation is responsible for ensuring safe systems of work including the completion of a risk assessment approved through local governance procedures.

This Guidance has been developed as part of an emergency response to the current Monkeypox outbreak and therefore does not follow normal NIPCM methodology and process.

Version history

Version	Date	Summary of changes
V1.0	01/06/22	First publication
V1.1	06/06/22	Greater clarity on symptomology associated with PPE use – section 2.2 Clarity on cleaning and PPE requirements – section 2.3 Inclusion of PPE requirements for vaccinators when vaccinating contacts who do not meet possible/probable/confirmed case definition – section 2.7
V1.2	08/07/22	Updated to reflect changes to HCID categorisation of MPX outbreak clade. Changes throughout the document to refer to MPX outbreak clade. Updated to include Department of Transport Multilateral Agreement M347 on the re-categorisation of waste for MPX outbreak clade to Category B.
V1.3	18/08/22	Update to reflect agreed name changes to Monkeypox variants with current outbreak variant identified as Monkeypox (Clade IIb)

Contents

1. General information

General information on Monkeypox (MPX) including case definitions, clinical pathways and contact tracing can be found in the PHS guidance: Management of Suspected Monkeypox in Primary and Community care.

This document outlines the infection prevention and control advice for healthcare workers who may be involved in the care of possible, probable or confirmed cases of MPX. The guidance is based on the published Principles for Monkeypox control in the UK four nations consensus statement from the UK Health Security Agency (UKHSA) and associated UKHSA guidance documents. Given the rapidly evolving nature of the current situation, content will be subject to frequent updates. The latest version should always be referred to for any updates. The guidance should be read in conjunction with the NIPCM and links to the appropriate sections of the NIPCM will be provided within this guidance.

Prior to April 2022, MPX was seen as a viral zoonotic disease was occasionally imported from Africa. Given the infrequent importations to reduce spread in healthcare and the community, and the limited information available about the disease course and outcome, the UK clinical and public health response to MPX was classified as a high consequence infectious disease (HCID). This was highly precautionary and designed for complete containment around single cases. It was also designated as a HCID prior to the confirmed availability of vaccine and treatment. High Consequence Infectious Disease is not a legal classification but is instead agreed by a UKHSA and NHS programme to enable a consistent approach to the clinical and inpatient management of infections that meet agreed criteria.

Since 13 May 2022, cases of MPX have been reported in multiple countries that do not have endemic MPX virus in animal or human populations, including countries in Europe, North America and Australasia. Epidemiological investigations are ongoing; however reported cases thus far have no established travel links to an endemic area. This suggests significant community transmission in multiple non-endemic countries in recent weeks. Similarly, the context has now changed to that of multiple cases in the UK and information on community spread within younger age groups and severity is accumulating rapidly. In the UK, all reported cases have been identified as the West African clade through rapid molecular testing. Community transmission is occurring in the UK with multiple generations of spread. Illness appears to be generally mild, consistent with other information about the West African clade.

The naming of variants for existing pathogens is normally the result of debate amongst scientists. In order to expedite agreement in the context of the current outbreak, WHO convened an *ad hoc* meeting on 8 August 2022 to enable virologists and public health experts to reach consensus on new terminology (Monkeypox: experts give virus variants new names (who.int)). This aligns the names of the monkeypox disease, virus, and variants—or clades—with current best practices. The proper naming structure will be represented by a Roman numeral for the clade and a lower-case alphanumeric character for the subclades. Thus, the new naming convention comprises Clade I, Clade IIa and Clade IIb, with the latter referring primarily to the group of variants largely circulating in the 2022 global outbreak.

In June 2022, the Advisory Committee on Dangerous Pathogens (ACDP) considered whether the HCID criteria apply currently to MPX in the context of the current outbreak. ACDP noted the data provided for UK cases show the vast majority are not clinically severe, that a therapeutic antiviral is available, and that a safe and effective vaccine is available and being deployed. The committee recommended that the clade of Monkeypox (Clade IIb) in current community transmission within the UK should no longer be classified as a HCID. Consensus has therefore been reached between UK Public Health Agencies that MPX Clade IIb in the UK should no longer be designated, and therefore managed, as a HCID. However, future importations of monkeypox (Congo Basin (Central African) Clade one (I) and West African Clade two (IIa)) should remain classified as an HCID.

Monkeypox is a hazard group 3 organism (ACDP/HSE). Other organisms in this category include Salmonella typhi, HIV, Hepatitis B and C, and Mycobacterium tuberculosis that are managed routinely in the community.

Transmission of Monkeypox (Clade IIb) is consistent with close direct contact. There is currently no evidence that individuals are infectious before the onset of the prodromal illness. For 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.

2. Patient management

The derogation of HCID status therefore means a change in how Monkeypox is defined. The operational definition going forward is therefore:

a. Monkeypox:

- **without** travel to West or Central Africa and without a link to a traveller from those regions **and/or**
- confirmed by sequencing to be Monkeypox (Clade IIb)

is not considered a high consequence infectious disease.

b. Monkeypox

- with a travel history to West or Central Africa, a link to a traveller from those regions **OR**
- with a link to an outbreak which is not Monkeypox (Clade IIb) OR iii. sequenced and known to be a non-outbreak clade

  OR
- which results from a new zoonotic jump in any country or setting

is considered a high consequence infectious disease.

This derogation of HCID status for Monkeypox is to ensure a proportionate response to deliver on achievable strategic outcomes. These principles do not replace the need for local dynamic risk assessments which remain key.

In preparation, healthcare settings that may receive and care for probable, possible, or confirmed Monkeypox (Clade IIb) cases should ensure that staff are:

- aware of what actions to take if a possible, probable or confirmed case presents;
- familiar with all IPC controls required as per this guidance.

2.1 Patient placement

In line with the hierarchy of controls, efforts should be made to perform telephone triage/assessment to help establish symptoms present and risk associated with potential Monkeypox in advance of any face-to-face contact where possible.

Possible, probable, or confirmed Monkeypox (Clade IIb) cases who require to be seen by healthcare staff within a healthcare facility should be placed in a negative pressure room (or a single neutral pressure room where negative pressure room is unavailable). Where there are minimal numbers of negatively pressurised rooms, these should be prioritised for confirmed cases.

All possible, probable, or confirmed patients should be provided with a Fluid Resistant Surgical Mask (FRSM) to wear where this can be tolerated and does not compromise their clinical care e.g., when receiving oxygen therapy.

2.2 Personal Protective Equipment

Table 1: Minimum PPE requirements for possible, probable, and confirmed Monkeypox (Clade IIb)

Definition categories	Minimum PPE required
Where symptoms are mild (this may include a localized rash) and there is no evidence of respiratory symptoms.	• **Gloves – single pair** Ensure Hand hygiene is performed appropriately prior to and after removal of gloves. • Fluid Resistant Surgical Facemask (FRSM) • Apron
Possible, Probable and Confirmed – Where symptomology includes respiratory symptoms, widespread rash **AND/OR** clinically deteriorating as a direct result of MPX **AND/OR** prolonged close contact with a patient and their environment e.g. an overnight inpatient admission stay	• **Gloves – single pair** Ensure Hand hygiene is performed appropriately prior to and after removal of gloves. • FFP3 respirator[1] • Fluid resistant gown/coveralls • Eye/face protection

[1] A full face visor is required in addition to a FFP3 respirator where the respirator is not fluid resistant. HCWs must be fit tested prior to donning a respirator and perform a fit check each time it is donned.

Donning and doffing step-by-step instructions can be found in Appendix 6 of the NIPCM.

ARHAI Scotland recognise that some ID Units will have established processes and procedures for HCID PPE which will be clearly defined as 'standard practice' for that area, which may include the application of a high level unified ensemble for all HCIDs. Should they choose to adopt these to prevent confusion they may do so.

2.3 Decontamination

Equipment in the room where a possible, probable or confirmed case is being managed should be kept to a minimum. Reusable patient care equipment should be dedicated to the patient as far as practicable. The Monkeypox (Clade IIb) virus will destroyed by hospital detergents and disinfectants.

Decontamination of reusable patient care equipment after use on the possible, probable or confirmed case should be in line with Appendix 7 of the NIPCM.

Cleaning and decontamination of the patient room within healthcare settings should be undertaken using:

- a combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
- a general purpose neutral detergent in a solution of warm water followed by disinfection solution of 1,000ppm av.cl.

Manufacturers' guidance and recommended product "contact time" must be followed for all cleaning/disinfection solutions.

Increased frequency of decontamination/cleaning schedules should be incorporated into the environmental decontamination schedules for rooms occupied by possible, probable, or confirmed Monkeypox (Clade IIb) cases where there may be higher environmental contamination rates e.g., inpatient rooms. Staff cleaning the room should wear PPE in line with section 2.2 whist the patient is still present.

Inpatient rooms must be terminally cleaned following resolution of symptoms, discharge and/or transfer of the possible, probable, or confirmed Monkeypox (Clade IIb) case. Equipment should be cleaned, linen bagged, and waste removed by the clinical staff who have been caring for the patient wearing the PPE outline in section 2.2. Curtains and bed screens should also be removed for laundering. Where domestic staff are required to remove curtains/screens they should do so wearing PPE outlined in section 2.2. Subsequent cleaning of the empty room to complete the terminal clean thereafter may be undertaken whilst wearing an apron, gloves and FRSM.

In primary care settings where a consultation with a possible, probable, or confirmed Monkeypox (Clade IIb) case has taken place, ensure thorough cleaning using the same products stated above once the patient leaves the room and wearing the PPE outlined in section 2.2. This must include all equipment and surfaces and as a minimum, a full floor clean at the end of the day.

2.4 Waste

The UN Transport committee have met, and the consensus is that waste from individuals suspected or confirmed to have Monkeypox (Clade IIb) no longer needs to be treated as category A waste.

Infectious waste from these individuals can be treated as healthcare (clinical) category B waste and can be disposed of in an orange bag for alternative treatment and does not have to be sent for incineration. The waste will be assigned to UN3291, clinical waste, unspecified, n.o.s. if there is any chemical or pharmaceutical contamination, the waste must be consigned in a yellow container (or purple if cytotoxic/cytostatic) and incinerated or sent to a permitted site for disposal as per national regulation.

The same advice applies to diagnostic samples/swabs which will be assigned to UN3373 Biological Substance **Category B**.

Laboratory cultures of Monkeypox (including Monkeypox (Clade IIb)) will continue to be assigned to **Category A** and will be carried under UN 3373 or UN 3291.

This is as per the Department for Transport Multilateral Agreement M347 under section 1.5.1 of ADR on the carriage of Monkeypox virus.

2.5 Linen management

Contaminated clothing and linen are a potential source of transmission. Care must be taken not to shake the linen and prevent dispersal of skin scales. All linen generated during the care of a possible, probable, or confirmed case of Monkeypox (Clade IIb) must be managed as infectious linen in line with Appendix 8 of the NIPCM.

2.6 Safe management of blood and body fluids

Spillages of blood and/or other body fluids associated with a possible, probable or confirmed case of Monkeypox (Clade IIb) must be treated immediately in line with Appendix 9 of the NIPCM.

2.7 IPC advice for MPX vaccination teams

If vaccinating a possible, probable, or confirmed Monkeypox (Clade IIb) case, the content of this guidance document should be followed.

If vaccinating asymptomatic contacts who **do not** fit the possible, probable, or confirmed case definition or HCWs as part of a routine response where that HCW has not had any exposure to a case of Monkeypox (Clade IIb), IPC requirements are those in line with standard IPC vaccination protocols and there is considered no additional risk. Gloves are not routinely required for vaccination. An SBAR detailing the evidence around this is available.

2.8 Visitors to an inpatient who is a possible, probable, or confirmed case of Monkeypox (Clade IIb)

Visitors to possible, probable, or confirmed Monkeypox (Clade IIb) inpatients should be restricted. If essential, for example carer/parents/guardians, individual advice should be sought from IPCT/HPT regarding the safest way to arrange a visit.