HSE Public Health: National Health Protection Office
FSS Sláinte Poiblí: An Oifig Náisiúnta um Chosaint Sláinte

Interim Guidance for the Public Health Management of Cases and Contacts of mpox – **Chapter 2 (Clade I Cases and their Contacts)**

Please note that this document should be used in tandem with other Interim Management of Mpox documents.

Readers should not rely solely on the information contained within these guidelines. Guidance information is not intended to be a substitute for advice from other relevant sources including, but not limited to, the advice from a health professional. Clinical judgement and discretion will be required in the interpretation and application of this guidance. This guidance is under constant review based upon emerging evidence at national and international levels and national policy decisions.
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VERSION HISTORY

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1.0	07/11/2024	Guidance developed.
1.1	03/03/2025	Review and update of IPC advice
1.2	07/04/2025	Updated NIAC link on p.12

Table of Contents

1.0 Presentation, testing and management of confirmed and highly probable MPXV Clade I cases

1.1 Testing Pathways

When MPXV Clade I is suspected, clinical assessment is undertaken in accordance with **relevant pathways** developed for ambulance service, community, acute and HIV/STI, maternity, and paediatric settings.

1.2 Case Definitions

These are the **case definitions** for probable and/or confirmed cases of mpox.

1.3 Health Risk Assessment

Newly identified cases of MPXV Clade I will undergo an individual health risk assessment for severity and risk factors (e.g. **predisposing or underlying conditions**[1] or medications affecting immune competence, untreated HIV infection, accommodation facilities etc). Those identified at increased risk of infection with MPXV Clade I may require hospitalisation and/or treatment with antivirals. The decision to isolate and monitor someone at home should be made on a case-by-case basis and based on clinical severity, care needs, risk factors for severe disease, possibility of having contact with persons with high risk for severe mpox (such as immunocompromised persons, infants and pregnant women) and their access to hospitalisation referral should their clinical condition deteriorate. These clinical decisions should be made by Infectious Diseases/Genitourinary Medicine/Clinical Microbiology Consultant-led teams.

1.4 Comprehensive Advice for those Isolating at Home

If risk assessment allows for home isolation, general advice for infected people who are self-isolating at home is available **here**. This includes general advice on self-isolation, cleaning, disinfection and waste disposal, avoiding close contact with others,

[1] World Health Organization (**WHO**) 2024. ***Sepsis***. Available URL: https://www.who.int/news-room/fact-sheets/detail/sepsis (Accessed: 11/09/2024).

pets, ending self-isolation, resumption of sexual activity and what to do if medical advice is required.

1.5 Access to Community Isolation Facility

If a case is well enough to be isolated outside hospital, but circumstances at home do not allow this, referral can be made to a community isolation facility. For information on contact details and referral form please see **here**.

1.6 Guidance for Health & Care Workers on Infection Prevention and Control (IPC) Precautions:

Ensure that for all clinical interactions with MPXV Clade I cases (i.e. confirmed and probable) that **personal protective equipment (PPE)**[2] is used in line **with National HCID IPC guidance**.

1.7 High Complexity Cases/Contacts:

National and Regional Public Health are available to support risk assessment and management of MPXV Clade I undertaken by colleagues in Infectious Diseases, Clinical Microbiology, Paediatrics, Maternity Services, and General Practice. The following scenarios are the more common (please note that this list is not exhaustive).

1.7.1 Isolation considerations:

- Where case(s) are unwilling to isolate, there may be a requirement to involve **Medical Officer of Health** in **regional Departments of Public Health**;
- In instances where hospitalisation is not deemed necessary, risk assessment about home isolation should be undertaken. If required, the option of isolation at the **National Infectious Diseases Isolation Facility (NIDIF)**.

[2] **PPE Recommended:** 1. Respirator Mask: FFP2/3, if person has respiratory symptoms. 2. Surgical Face Mask, Type II R, if person has NO respiratory symptoms (and Chickenpox unlikely). 3. Eye protection (Goggles/Visor), if there is a risk of splash to the face and eyes e.g. taking diagnostic tests. 4. Disposable nitrile gloves. 5. Disposable plastic apron. Impervious Long-sleeved gown may be required as determined by the IPC point of care risk assessment.

1.7.2 Testing:

- Where individual(s) meet clinical criteria for mpox but are unwilling to have microbiological testing for confirmation.

1.7.3 Pregnancy:

- Where case(s) or contact(s) are pregnant, there will be need to link with relevant Maternity Services.

1.7.4 Paediatric:

- Where case(s) or contact(s) are children (i.e. under 16 years of age), attend childcare facilities or live in **congregate setting(s)**[3], there will be need to link with relevant Paediatric Services, and if required additional consultation with Paediatric Infectious Diseases in Children's Health Ireland (CHI) may be considered.

1.7.5 Congregate setting(s):

- Where case(s) or contact(s) reside in a congregate setting, there will be need for multidisciplinary consultation with Public Health, National Social Inclusion, and Regional Health Area structures, as considerations around risk mitigation for wider contagion will need to be balanced.

1.7.6 International Travel:

- Where case(s) or contact(s) have extended travel in close contact with other travellers on planes, ferries etc during their infectious period or period of surveillance. There will be a need to link with transport providers (i.e. airlines or ferry services) to assist with identification of contacts who need to be alerted, advised, and placed on surveillance programme. A risk assessment should be undertaken taking into consideration factors such as clinical presentation for example the number and location of lesions, were the lesions covered, presence of

[3] **Congregate setting(s):** refer to a range of facilities where people (most or all of whom are not related) live or stay overnight and use shared spaces (e.g., common sleeping areas, bathrooms, kitchens) such as: homeless shelters, refuges, group homes and State-provided accommodation for refugees and applicants seeking protection e.g. UCTAT, IPAS. This will also cover prisons, military bases, boarding schools, and detention centres. Those living or staying in the facility are referred to as residents.

oral lesions, presence of respiratory symptoms etc. Other factors include: the duration of time the case(s) were using the transport providers (i.e. airlines or ferry services); the risk to those undertaking cleaning/decontamination prior to identification of the case(s); and risk to the subsequent occupant(s) using the transport providers (i.e. airlines or ferry services) of the space with risks from possible fomite transmission. Recommendations for the decontamination of a vehicle are as follows:

- Wipe down all hard surfaces using a standard detergent or detergent wipes;
- If the individual's lesions were covered when they travelled in the vehicle, risk assess as contamination of seats may be minimal. Non-fabric seats such as leather/vinyl can be cleaned using standard detergent or detergent wipes. Fabric seats can be steam cleaned. The transport vehicle doors should be kept open during this process;
- Additional information on cleaning/decontamination for aircrafts can be found **here**.

1.7.7 Humanitarian Aid Worker(s):

- Where individual(s) have travelled to endemic (i.e. high community transmission) areas, they should be entered into a surveillance programme within the 21 days from departure of endemic area with the local Department of Public Health;
- To ensure appropriate follow-up of humanitarian aid workers (HAWs) from affected areas, agencies deploying HAWs are asked to complete a return HAW form for each HAW deployed and return it to HPSC. Of note, the Defence Forces may sometimes submit forms by hand delivery. See **Appendix A**; and
- If required, information can be obtained **here**.

1.7.8 Outbreaks:

- Suspected or confirmed clusters or outbreaks including sex-on-premises locations (e.g. saunas, bathhouses, or other personal service settings).

Where two or more cases are linked within 21 days, this should be alerted to local Public Health.

2.0 Identification & Management of Contacts

2.1 Contact Tracing

Contact tracing and partner notification are important measures in the response to mpox and previously published guidance on the HPSC website remains relevant.

Contact tracing is the process of identifying people in close contact with a person confirmed with the disease who may therefore be at higher risk of becoming infected. Through contact tracing, identified contacts can be informed of their risk and closely followed, which enables early detection of symptoms and reduces onward transmission.

Close contacts may be **sexual partners**[4], household contacts, health professionals, or other people who had prolonged physical contact with a person with mpox. Individuals who had no close physical contact but were near a person with mpox for a prolonged period of time, e.g. sharing an office and sharing the same equipment, or being seated within three rows of seat of a person with mpox during a long flight, may also qualify as a close contact. However, this would require a case-by-case assessment which should consider the duration and exact type of contact and timing of the contact relative to the onset of rash.

Contact persons need to be provided with tailored information to understand the clinical and epidemiological aspects of the disease and the ways to prevent onward transmission. Also, when possible, contacts need to be followed up by public health authorities or their healthcare provider 21 days after the last potential infectious exposure based on the mpox incubation period. Contact tracing of newly identified mpox cases should be undertaken with discretion.

[4] Contact tracing and post exposure prophylaxis (PEP) vaccination for sexual contacts of mpox cases are generally undertaken by the sexual health services (SHS). This will be set out in a memorandum of understanding (MOU), currently in development, to be agreed between Public Health and their local Sexual Health Services.

Based on the current epidemiological knowledge of transmissibility, close contacts of persons with mpox do not need to quarantine or be excluded from work, if no symptoms develop. However, during the 21-day monitoring period, asymptomatic contacts are advised to avoid sexual contact with others and physical contact with persons at risk of severe disease.

2.1.1 Maternal & Child Care

Children can get mpox if they have close contact with someone who has symptoms. Children can be exposed to the virus at home from siblings, parents, caregivers, or other family members through close contact. In some settings in Africa, children and adolescents may be exposed through hunting or trapping activities or consumption of insufficiently cooked meat. Adolescents who have engaged in sexual activity with someone with mpox can also be exposed. The mpox rash can at first resemble other common childhood illnesses, such as chickenpox and other viral infections. If a child you are caring for has symptoms that could be mpox, seek advice from a healthcare provider, and if there has been exposure to mpox, this should be highlighted in the interaction with healthcare provider.

Children may be at greater risk of severe mpox than adults. They should be closely monitored until they have recovered in case they need additional care. A Health & Care Worker (H&CW) responsible for the child may advise that they are cared for in a health facility. In this situation, a parent or caregiver who is healthy and at low risk of mpox will be allowed to stay with them.

If parent/caregiver have confirmed or probable mpox and is breastfeeding, they should link with healthcare provider for advice. They will assess the risk of transmitting mpox as well as the risk of withholding breastfeeding from the infant. If it is possible for the parent/caregiver to continue to breastfeed and have close contact, they will advise them on how to reduce the risk by taking other measures, including covering up lesions. The risk of infection will need to be carefully balanced with the potential harm and distress caused by interrupting breastfeeding and close contact between parent and child. It is not yet known whether the MPXV can be spread from parent to child through breastmilk; this is an area in need of further study.

The information which Department(s) of Public Health gather from contact tracing is also relevant to better understand the spread of the disease in the population, the transmission characteristics of the virus, and to identify settings or population groups where targeted interventions are likely to be most effective.

2.2 Indications for MPOX Testing

Any individual/contact meeting the definition for a probable case should be offered PCR testing for mpox, where resources allow. In the absence of skin or mucosal lesions, PCR can be done on an oropharyngeal, anal or rectal swab. However, the interpretation of results from oropharyngeal, anal and rectal swabs requires caution: while a positive result is indicative of mpox, a negative result is not enough to exclude MPXV infection. PCR testing of blood is not recommended for surveillance and diagnosis, as MPXV viremia is likely to occur early in the course of infection and has a short duration, thus false negative test results are to be expected.

Due to the range of conditions that cause skin and mucosal rashes, it can be challenging to differentiate mpox solely based on the skin and mucosal clinical presentation, particularly in the early stages of rash, for cases with an atypical presentation, or for cases linked to sexual transmission which may not match classic descriptions of mpox rash. The decision to test should be based on clinical and epidemiological factors, linked to assessing the likelihood of infection. When clinical suspicion for mpox is high due to history, clinical presentation and/or atypical response to syndromic management of sexually transmitted infections, the identification of an alternate pathogen that causes rash illness should not preclude testing for MPXV, as coinfections have been identified. Given the epidemiological characteristics observed in mpox outbreaks, criteria such as having had contact with a person with mpox, being a H&CW, being a man who has sex with men, being a sex worker or otherwise reporting having multiple sex partners in the previous three weeks, can all be suggestive of the need to test for MPXV.

Where children or adolescents may be at risk, particularly but not exclusively in areas where mpox is endemic and continues to occur, the differential diagnosis for rash and fever illness should include mpox and investigation should be initiated. Following travel

to countries with animal-to-human transmission, epidemiological criteria to test for MPXV include known or presumed contact with wild animals (dead or alive) and/or contact with sick animals in the 21 days before the onset of symptoms.

For study purposes, countries can retrospectively expand their testing to residuals of specimens collected from patients presenting for sexually transmitted infection (STI) screening and/or with symptoms suggestive of mpox.

2.3 Surveillance

Clinicians and laboratories are **legally required to report certain infectious diseases** to the Medical Officer of Health of their regional Department of Public Health. In Ireland, the HPSC has been encouraged to ensure that clade and subclade determination reporting of cases is possible on the national reporting system, this approach will allow for more granular insight into the epidemiology of mpox.

Enhanced surveillance forms and related protocols are in place to ensure effective delivery of contact tracing services and surveillance requirements. The regional Department of Public Health where the case resides will remain involved in the investigation of non-sexual contacts. The regional Department of Public Health will also remain available to advise Sexual Health Service (SHS) on the public health management of contacts of high complexity, as required. Some of these may arise and are listed above (*NB: this list is not exhaustive*).

2.4 Contact Management

H&CWs and non-H&CWs management based on exposure risk can be found in **Chapter 4**; the related monitoring forms are appendices to Chapter 4.

2.5 Vaccination

Vaccination campaigns were implemented in the EU/EEA and other countries to control the outbreak of clade IIb MPXV in 2022, with a third-generation non-replicating

smallpox vaccine authorised by the European Medicines Agency (EMA) for protection against mpox in individuals aged 18 years and above.

In the present epidemiological situation, mass vaccination and general travel vaccination in the Ireland is not required; current vaccination approaches should follow an 'at risk' principle:

- Primary preventative (pre-exposure) vaccination (PPV);
- Post-exposure preventative vaccination;[5] and
- Vaccination to certain individuals at high risk.

The most current vaccine guidance can be found **here**.

[5] Pending clarification around funding for post-exposure prophylaxis vaccination administration by Sexual Health Services for sexual contacts on mpox cases, review on case-by-case basis will need to be considered with Departments of Public Health and local Sexual Health Services.

3.0 Escalation thresholds for mpox trends

Escalation thresholds for raising concern re mpox cases have been agreed as follows:

1. The number of cases in any transmission network is increasing (e.g. average frequency greater than one case a week over a 4-week period); and
2. The geographical pattern of cases is changing.

3.1 Action:

- Enhanced review within Public Health to see if change continues over time and is experienced elsewhere too.

If any of the following are seen:

1. Community transmission outside the main networks of transmission with no identifiable link to another case (no travel history or links);
2. Evidence of re-infection or vaccine failure (individual cases of);
3. Clear evidence that cases are rising (e.g. consistent increase in weekly average number of cases);
4. Clear evidence that community transmission is occurring across wider geographical areas;
5. A larger cluster or outbreak (e.g. following a particular event, or with a rapid increase in a short period); and
6. Increase in severity of cases.

3.2 Action:

The HPSC should alert national partner organisations including Clinical Lead Sexual Health, STI/ID Clinicians, Infectious Disease and Clinical Microbiology Clinicians, Paediatricians, General Practitioners, NGOs etc, update Dynamic Risk Assessment and consider reconvening the National Incident Management Team (N-IMT) mpox. This should be led by Public Health.

4.0 Infection prevention & control

The use of a point of care risk assessment (PCRA) for all individual(s) should aid rapid identification, selection of appropriate PPE and implementation of transmission-based precautions quickly. PCRA resources can be found **here**.

Precautions should be used when:

- An individual presents with fever and vesicular/pustular rash (suspected case). Any lesions or respiratory secretions should be considered infectious material; and
- Close contacts of mpox present with other symptoms suggestive of mpox but rash is absent e.g. fever, chills, swollen lymph nodes, exhaustion, muscle aches and backache, headache and / or respiratory symptoms.

For detailed guidance on infection prevention and control (IPC) for MPXV Clade I, refer to the **National HCID IPC guidance**.

Confirmed case(s) who do not require hospitalisation for medical indications may be isolated in the household setting and other non-healthcare settings using appropriate infection, prevention and control precautions. Prevention of transmission of infection by respiratory and contact routes is also required in the household setting. Scabs are also infectious and care must be taken to avoid transmission through handling bedding, clothing etc. The ability to implement infection, prevention and control precautions in a household setting is likely to vary and should be based on a Public Health Risk Assessment (PHRA). The following factors should be taken into consideration:

- Type of household setting e.g. in the home setting, apartment complex, direct provision centre, hostel, etc.;
- The nature and extent of lesions in each case;
- Unable to avoid contact with immunosuppressed people, pregnant women, and children aged under 5 years;
- The presence of additional infected or uninfected persons or pets in the home.
- Social and psychological factors; and

- If the individual does not have mental and/or physical capacity to undertake their own self-care.

If unable to fulfil isolation requirements then a co-ordinated response to manage the patient outside a hospital setting or following discharge of clinically well patients is managed by the **National Infectious Diseases Isolation Facility (NIDIF)**, as appropriate.

The following principles should be considered and adopted to the greatest extent possible in the household setting.

4.1 Hand Hygiene

- Alcohol-based hand rub/or soap and water are acceptable methods for hand hygiene;
- When hands are visibly soiled, soap and water is the recommended hand hygiene method;
- Hand hygiene should always be performed after the removal of gloves; and
- Refer to hand hygiene posters **here**.

4.2 Transmission Based Precautions

In accordance with **National Irish IPC Guidelines**, other national (*i.e*. **National HCID IPC guidance**.) and international guidance, **airborne, droplet and contact precautions** are recommended.

4.2.1 Confirmed/Highly suspected Case MPXV Clade I

- Following a point of care risk assessment;
- Case should be advised to perform hand hygiene;
- Case should wear a medical mask (if they have respiratory symptoms);
- Case should be immediately placed into an Airborne Infection Isolation Room (AIIR) where available or single room (with *en suite* facilities) where available and if not available a single room with access to a dedicated commode for

individual use with the door closed, for assessment upon entry to the healthcare setting;

- If the case must leave the room, a medical mask should be worn, if medically able to tolerate or clinical condition allows; and advised to perform hand hygiene;
- Skin lesions should be kept covered with a gown, clothes, sheet or bandage, except during examination; and
- The environment (case/patient) room including hard surfaces and equipment should be cleaned and disinfected after use, as per **National Irish IPC Guidelines**, other national (*i.e.* **National HCID IPC guidance**.) and international guidance.

4.2.2 Health & Care Worker – Personal Protective Equipment (PPE)

- Fit-tested and seal-checked FFP2/3 respirator;
- Fluid repellent gown (cuffed, long sleeve);
- Gloves; and
- Eye protection (e.g., face shield or goggles).

All PPE should be donned before entering the individual's room. All PPE should be disposed of prior to leaving the isolation room except for the respirator, which should be removed, outside of the room once the door is closed, and hands should again be cleaned. Supporting posters are available **here**.

All PPE (including respirators) must be discarded after each episode of contact with the confirmed/highly suspected case of MPXV Clade I and hand hygiene performed.

4.2.3 Additional Considerations

- Only essential staff should enter confirmed case's room;
- Immunocompromised and pregnant H&CWs should not directly care for individual(s) with confirmed/highly suspected MPXV Clade I infection; and
- As other infectious diseases might be the cause of presenting symptoms, all H&CWs should be up to date with immunisations for vaccine preventable diseases.

4.2.4 Room selection/case placement

- Case should be placed in an AIIR, when available;
- If an AIIR is not available, the case should be placed in a single room with *en suite* facilities with the door closed. If *ensuite* facilities are unavailable, ensure the patient is provided with a dedicated commode for their individual use;
- For isolation in congregate setting, a single room with a dedicated bathroom is required and commode can be used if dedicated bathroom not available to the assigned single room, if this is not feasible, consider referral for voluntary isolation to the **National Infectious Diseases Isolation Facility (NIDIF)**;
- Visitors should be restricted to those necessary for care or compassionate grounds; and
- Maintain a record of all individual(s), H&CW(s) and visitor(s) who have contact with the confirmed/suspected case of MPXV Clade I.

4.3 Cleaning and Disinfection

4.3.1 Equipment

- Ensure Personal protective equipment is available and all staff carrying out the cleaning should wear PPE: for example: single use gloves, disposable long sleeved fluid resistant gown, FFP2/3 respirator mask and eye protection. It is important to advise staff to not touch their face while wearing PPE and change their gloves if they become torn or contaminated;
- Staff may need advice and support especially staff carrying out the cleaning and disinfection in areas outside healthcare settings with elements such as putting on and taking off PPE safely, advising not to touch their face whilst wearing PPE, ensuring that they do not contaminate other areas/equipment when removing it and supporting with hand hygiene technique (before and after donning and doffing PPE). In addition to standard detergent cleaning, perform disinfection using a chlorine-based product such as sodium hypochlorite or another appropriate disinfectant. For routine use, a chlorine-based disinfectant should be used with available chlorine at 1000-parts per million. For further details can be found in **National Irish IPC Guidelines**, under "***Table 3: Summary of good practice statements***"; "***Table 9: Cleaning requirements***

for routine environmental cleaning"; and "***Figure 4: Processes for routine cleaning and product choice***".

- Use standardised cleaning and disinfection protocols;
- Ensure dedicated equipment to a single case; and
- Clean and disinfect all reusable equipment. Follow the manufacturer's directions for concentration, contact time, and care and handling.

4.3.2 Environmental Surfaces

- All contact surfaces where a confirmed/suspected case of MPXV Clade I has interacted with should be cleaned and disinfected with CE approved hospital grade disinfectants for use in healthcare sector;
- Disposable cleaning cloths and wipes should be used and discarded as per clinical waste after each clean. All cleaning cloths used must not be reused and must be disposed of as clinical waste;
- Surfaces should be physically cleaned and disinfected. This process must involve either:
    - Two-step clean - a physical clean using a detergent followed by disinfection with a chlorine-based product such as sodium hypochlorite or another appropriate disinfectant; and
    - Two in one clean - a physical clean using a combined detergent and a chlorine-based product such as sodium hypochlorite or another appropriate disinfectant. For further details can be found in **National Irish IPC Guidelines**, under "***Use of Disinfectants***".
- When using sodium hypochlorite to disinfect hard surfaces the following should be considered:
    - Clean first with a neutral detergent as environmental surfaces should be clean and free of organic matter.
    - Allow sufficient time to kill the microorganism (at least 10 minutes surface contact time for some organisms). Perform disinfection using a chlorine-based product such as sodium hypochlorite or another appropriate disinfectant in addition to standard cleaning in specific circumstances as required based on institutional guidance or risk assessment. For routine use, a chlorine-based disinfectant should be

used with available chlorine at 1000-parts per million. For further details can be found in **National Irish IPC Guidelines**, under "***Use of Disinfectants***".

- Clean and disinfect all surfaces including frequently touched surfaces including chairs, public/shared bathrooms, doorknobs, call bell pulls, toilet flush handles, tap handles and wall surfaces that may have been frequently touched by the case;
- Use standard cleaning and disinfection protocols;
- Activities such as dry dusting, sweeping, or vacuuming must be avoided. Wet or damp cleaning methods are preferred;
- Vacuuming using a vacuum with a high-efficiency air filter (renewed in line with manufacturer's instructions) may be deemed essential in some contexts, in which case ensure the person vacuuming wears a well-fitting mask or respirator and the room is well ventilated before and after cleaning. Soft furnishings including carpet can also be wet vacuumed. Following cleaning of soft furnishings, they must be allowed to dry before they are reused. Steam cleaners (if used) need to be disinfected after use, following the manufacturer's instructions;
- Choosing a disinfectant that is compatible with the surface material is integral to avoid damage to the surface;
- When using sodium hypochlorite to disinfect hard surfaces the following should be considered:
    - Environmental surfaces should be clean and free of organic matter;
    - Allow sufficient time to kill the microorganism (at least 10 minutes surface contact time for some organisms); and
    - A dilution of sodium hypochlorite or sodium dichloroisocyanurate (NaDCC) should be made up fresh just before use in accordance with the manufacturer's instructions to provide the required parts per million of available chlorine such as 1000 parts per million (ppm).
- In general, for chlorine based disinfectant wet contact times of 2 to 10 minutes are required depending on the microorganism. Wet contact times refers to the period of time during which the surface being disinfected should remain with the disinfectant solution. Guidance on contact times from the manufacturer of

the disinfectant in use and from the manufacturer of the item being disinfected should be consulted and followed;

- If a non-chlorine-based disinfectant is used it should be a product suitable for use with bactericidal (EN16615), sporicidal (17126) and virucidal (EN14476) activity as required and be CE marked;
- For further details can be found in **National Irish IPC Guidelines**, under "***Use of Disinfectants***";
- Where an individual has used public/private transport.

4.3.3 Laundry (such as linens, towels, clothing, bedding etc)

- When handling soiled laundry (clothing, towels, bedding), care should be taken to avoid contact with the worker's skin and clothing. Wear appropriate PPE (gloves, gown, fit-tested and seal-checked FFP2/3 respirator and eye protection) during collection and bagging of all linens at the point of use;
- Laundry should never be shaken or handled in manner that risks dispersing infectious material into the air or onto the surrounding surfaces e.g. when changing a bed or making a bed;
- If the person is self-caring (in a non-healthcare facility) advise them how to change bed linen as outlined above and place directly into the linen receptacle to minimise the risk of handling of infected linen;
- Avoid unprotected contact with lesion material that may be present on the laundry. The laundry materials should carefully be placed in a leak-proof or alginate bag, sealed or tied and placed inside an impermeable bag for transport to laundry area; and
- In ambulatory care settings, standard medical laundry facilities should be used. If not available or in household settings, the items may be washed separately in a standard washing machine using hot water (60 degrees Celsius) with detergent and must be completely dried in a commercial dryer.

4.4 Containment and Disposal of Contaminated Waste

- Wear appropriate PPE to protect against exposure to blood and body substances during handling of waste; perform hand hygiene following the correct technique and as per WHO 5 moments:
- All waste generated from isolation rooms should be considered as healthcare risk waste. Such waste should be contained in the appropriate receptacle, identified by colour and label, and disposed of according to the facility waste management plan;
- Bin bags should be securely sealed prior to removing from waste receptacle to avoid potential exposure to microorganisms;
- Bin bags should be removed to designated external waste disposal point after removal from bin;
- Waste bins should be included on cleaning and disinfection schedule;
- Contaminated disposable items should be discarded according to manufacturer's instructions and in line with local facility waste management plan for healthcare risk waste or high-risk waste in non-healthcare facilities; and
- In non-healthcare settings, dispose of any items in domestic bag and normal waste stream.

4.5 Terminal Cleaning and Disinfection of the Environment

- Terminal cleaning and disinfection is the thorough cleaning/disinfection of all surfaces including floors and re-useable equipment following:
    - A single case or outbreak of MPXV Clade I;
    - Upon discharge/transfer of case(s) of MPXV Clade I from a facility/setting;
    - Upon the death of case(s) of MPXV Clade I from a facility/setting; or
    - Completion of appropriate period of isolation following recovery from confirmed infection of MPXV Clade I.
- Cleaners should wear PPE as outlined above during cleaning and disinfection.
    - The use of chlorine-based disinfectant with available chlorine at 1,000 parts per million, e.g. sodium hypochlorite disinfection in addition to

cleaning with a detergent solution is recommended for terminal disinfection in healthcare facilities;

- All disposable items in the patient's room should be discarded as healthcare risk waste or domestic waste in non-healthcare settings;
- Privacy curtains must be changed; and
- Equipment/supplies that cannot be cleaned and disinfected must be discarded.
- See above section for greater detail.

4.6 Ending self-isolation

Arrangements for individual(s) should be considered on a case-by-case basis. As a guide:

- Based on Department of Public Health risk assessment, close contacts for whom extenuating circumstances apply e.g. lives with an immunocompromised family member, may be requested to self-isolate and monitor for symptoms 21 days from date of last exposure. Further advice is available **here**;
- Those with suspected MPXV Clade I infection should have recommended isolation precautions maintained until mpox infection is ruled out; and
- Those with confirmed MPXV Clade I infection should have recommended isolation precautions maintained until all exposed lesions have crusted; these crusts have separated, and a fresh layer of healthy skin has formed underneath.

4.6.1 Hospital de-isolation criteria should include:

- **Clinical criteria:** The patient is judged clinically well enough for safe de-isolation as judged by the clinical team managing the patient.
- **Laboratory criteria:**[6] The patient is polymerase chain reaction (PCR) negative on all 3 of the following samples:
  - EDTA blood[7]
  - urine
  - throat swab

[6] **Laboratory criteria** are only relevant for MPVX Clade I infections.
[7] It is acceptable not to send EDTA blood if no sample was sent previously because the patient was well throughout admission.

- **Lesion criteria:** The following criteria all apply:
  - there have been no new lesions for 48 hours
  - there are no mucous membrane lesions
  - all lesions have scabbed over, all scabs covering the lesions have dropped off, and a fresh layer of skin has formed underneath.

4.6.2 Discharge from an isolation facility or isolation to another hospital ward, a different in-patient facility or a residential facility.

Discharge from an isolation facility or ward to another hospital ward, different inpatient facility or residential facility can only be considered if the de-isolation criteria in the clinical, laboratory and lesion criteria sections above are all met.

4.6.3 Discharge from hospital to home

Patients meeting the clinical, laboratory and lesion criteria as stated above can be discharged from hospital to home without requirement for ongoing isolation (that is, full de-isolation).

Patients meeting the clinical criteria but not meeting either laboratory or lesion criteria may be discharged from hospital to continue isolation at home where it is safe to do so after assessment by their treating clinician. They must be able to isolate away from any members of their household who are immunocompromised people, pregnant women, and children aged under 5 years. This also applies to those living in congregate settings.[3]

Patients with any lesions should remain in regular contact with their clinician until all lesions have scabbed over and all scabs have dropped off. Ongoing contact may be required after de-isolation.

Complex and severe cases, with slow clinical and virological resolution may require additional specialist guidance on risk management following discharge from hospital on a case-by-case basis.

4.6.4 Actions:

Individual(s) may be able to end self-isolation once the following clinical and lesion criteria have been met.

The individual:

- Has not had a high temperature for at least 72 hours;
- Has had no new lesions in the previous 48 hours;
- All exposed lesions have scabbed over:
    - In addition, any lesions on the face, arms and hands have scabbed over, all the scabs have fallen off and a fresh layer of skin has formed underneath
- Has no lesions in the mouth.

If all the points above are met, the individual may be able to stop self-isolating but should contact their medical team for further advice.

The individual should continue to avoid close contact with young children, pregnant women and immunosuppressed people until the scabs on all their lesions have fallen off and a fresh layer of skin has formed underneath. This is because they may still be infectious until the scabs have fallen off.

After their self-isolation has ended, they should cover any exposed remaining lesions (i.e. lesions not on the face, arms and hands) when leaving the house or having close contact with people in their household until all the scabs have fallen off and a fresh layer of skin has formed underneath.

4.7 Transportation of confirmed/probable MPXV Clade I Cases

If an individual with confirmed or probable mpox requires transportation, the individual should ideally not use public transportation. If patient transport services are used, then they should be informed that the individual has probable or confirmed mpox. The individual should be wearing a surgical face mask, and lesions covered during transport. The receiving healthcare setting should be informed before the individual's

arrival of the diagnosis and need for airborne, droplet and contact precautions. The transporting vehicle will require decontamination. The transport guidance using Ambulance Service might be of relevance, and this can be found **here**.

5.0 Occupational mpox exposures

This section provides guidance in assessing a potential occupational exposure of mpox in the healthcare/non-healthcare settings. The occupational risk assessment is essential in ensuring the workplace remains safe for staff and for the individual(s) who require diagnosis and care to prevent further transmission of mpox.

5.1 Background

Airborne, droplet, and contact precautions should be employed for all suspect, and confirmed cases of mpox. Any lesions, body fluids or respiratory secretions and contaminated materials, such as bedding, should be considered infectious. At the present time the risk of transmission in occupational setting appears to be very low. It is unknown if aerosol transmission can occur, if risk of transmission is associated with the stage of illness (prodrome, rash, systemic symptoms) or if there are case-related factors such as pregnancy, immune suppression, or young age that may be associated with how much virus a person excretes or if they are more likely to have transmissible virus in the upper respiratory tract.

5.2 Exposureexposre

If a worker had contact with an individual who is diagnosed with MPXV Clade I and was not wearing appropriate PPE consistent with airborne, droplet, and contact precautions, an assessment of the risk to the worker should be conducted.

5.2.1 Defining an exposure

The purposes of this section is to define the worker exposures and mitigate the risk of transmission to others (both colleagues and other individuals).

When adequate PPE is **not** used (see below), an **exposure** can be defined as:

- Worker has skin/mucosa to skin contact with a case;
- Worker has skin/mucosa contact with a case's biological fluids, secretions, skin lesions or scabs;
- Worker has skin/mucosa contact with surfaces or objects contaminated by a case's secretions, biological fluids, skin lesions or scabs; and

- Face-to-face interaction with a case.

All exposures should be considered on a case-by-case basis to determine level of risk.

When assessing the level of risk exposure, consider the length of time (transient versus prolonged) and proximity to the case, other case factors (drooling, coughing, immune suppression), use of PPE and any skin/mucosa contact with the person or their environment in the assessment.

5.3 Working post-exposure: Length of time and frequency of symptom monitoring

A worker may continue to work post-exposure, if they monitor for **symptoms** and stop working if they development any symptoms, leave work immediately and isolate, inform healthcare provider and abstain from all sexual contact(s). All exposed worker(s) should wear PPE appropriate for their occupational roles.

Monitoring mpox details are available **here**.

Workers with higher-risk exposures should not interact with those who are immunosuppressed, pregnant, giving birth, or children < 5 years of age for 21 days since the last high(er) risk exposure to a person with mpox. See Chapter 4 for more information on risk exposures.

Consider exclusion from work following a risk assessment for 21 days from date of last exposure, especially if work involves contact with immunosuppressed people, pregnant women, or children under 5 years (not limited to H&CWs). Risk assessment around redeployment to different area may be considered.

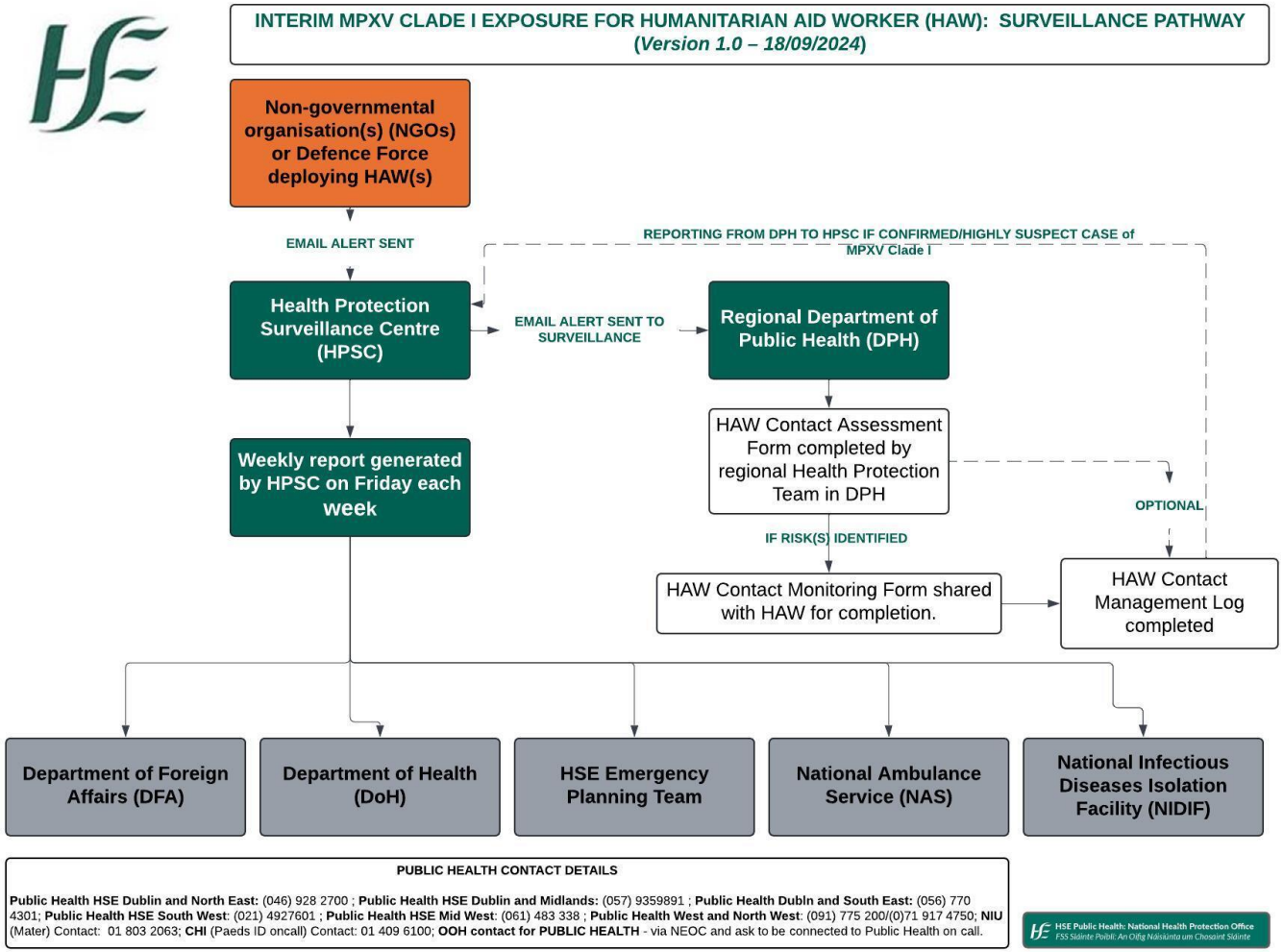
5.4 Management of Exposed Worker in Workplace Who Develops Symptoms

In the event a worker develops symptoms of mpox, they must stop work and immediately report to this to their line manager and arrange for clinical assessment from a healthcare provider. An investigation should be conducted to determine if the

source of infection was workplace or community acquired. A potentially workplace acquired case would be considered a sentinel event and should be reported promptly to Public Health and investigated fully.

Advice around environmental decontamination following an occupational exposure should be also given.

Appendix A


INTERIM MPXV CLADE I EXPOSURE FOR HUMANITARIAN AID WORKER (HAW): SURVEILLANCE PATHWAY
(Version 1.0 – 18/09/2024)
Non-governmental organisation(s) (NGOs) or Defence Force deploying HAW(s)
EMAIL ALERT SENT
REPORTING FROM DPH TO HPSC IF CONFIRMED/HIGHLY SUSPECT CASE of MPXV Clade I
Health Protection Surveillance Centre (HPSC)
EMAIL ALERT SENT TO SURVEILLANCE
Regional Department of Public Health (DPH)
Weekly report generated by HPSC on Friday each week
HAW Contact Assessment Form completed by regional Health Protection Team in DPH
OPTIONAL
IF RISK(S) IDENTIFIED
HAW Contact Monitoring Form shared with HAW for completion.
HAW Contact Management Log completed
Department of Foreign Affairs (DFA)
Department of Health (DoH)
HSE Emergency Planning Team
National Ambulance Service (NAS)
National Infectious Diseases Isolation Facility (NIDIF)
PUBLIC HEALTH CONTACT DETAILS
Public Health HSE Dublin and North East: (046) 928 2700 ; Public Health HSE Dublin and Midlands: (057) 9359891 ; Public Health Dubln and South East: (056) 770 4301; Public Health HSE South West: (021) 4927601 ; Public Health HSE Mid West: (061) 483 338 ; Public Health West and North West: (091) 775 200/(0)71 917 4750; NIU (Mater) Contact: 01 803 2063; CHI (Paeds ID oncall) Contact: 01 409 6100; OOH contact for PUBLIC HEALTH - via NEOC and ask to be connected to Public Health on call.
HSE Public Health: National Health Protection Office
FSS Sláinte Poiblí: An Oifig Náisiúnta um Chosaint Sláinte