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 & II 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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1.1	03/03/2025	Review and update of IPC advice
1.2	07/04/2025	Updated NIAC link on p.12
1.3	11/09/2025	Update to align with non HCID guidance

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

1.1 Testing Pathways

When mpox virus (MPXV) infection 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 infection 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 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

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

Microbiology Consultant-led teams. Most cases can be managed in the home setting.

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, 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 cases (i.e. confirmed and probable/possible) that **personal protective equipment (PPE)2** is used in line **with IPC Precautions for healthcare workers guidance**.

[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 High Complexity Cases/Contacts:

National and Regional Public Health are available to support risk assessment and management of MPXV cases/contacts 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 voluntarily, there may be a requirement to involve the regional **Medical Officer of Health** in **Regional Departments of Public Health** for consideration of mandatory isolation;
- In instances where hospitalisation is not deemed necessary, risk assessment about home isolation should be undertaken, or if home isolation is not possible post-discharge from hospital, it is imperative that appropriate accommodations are made to support the individual's recovery and prevent further transmission. Therefore if required, consider the option of isolation at the **National Infectious Diseases Isolation Facility (NIDIF)**.

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 accommodation setting, there will be need for multidisciplinary consultation with Public Health, Social Inclusion, and Regional Health Area structures, as considerations around risk mitigation for wider contagion will need to be balanced.
- Where the congregate setting is State-provided accommodation for refugees and/or applicants seeking protection, the respective Government departments need to be informed, as per the IPAS Infectious Disease Protocol (Public Health) and UCTAT Infectious Disease Protocol (Public Health).

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 a 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 oral lesions, presence of respiratory symptoms etc. Other factors

[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. The **risk of transmission is significantly higher**. In these environments, even general mpox cases may warrant **enhanced infection prevention and control precautions**, including temporary isolation, and improved ventilation.

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**.

1.7.8 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 the Regional Departments of 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 one metre (i.e. same rows/in front/behind; all within car/van) for at least 15 minutes,[5] 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.

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

[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.
[5] Consideration should be given when undertaking Public Health Risk Assessment (PHRA) for contact tracing for airline contacts. This should include evaluating seating configurations such as 2:2, 3:3, and 3:4:3 patterns, as these can impact the inclusivity of passengers, particularly those who need to be included in contact tracing efforts.

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.[6] 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 Regional 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.

[6] **Safeguarding Note:** In line with the *Children First Act 2015* and the *Children First: National Guidance for the Protection and Welfare of Children (2017)*, any concerns about a child's welfare—including suspected mpox exposure in contexts that may indicate abuse or neglect—must be reported to Tusla, the Child and Family Agency. All healthcare professionals are reminded of their responsibilities as mandated persons under the Act.

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;[7] and
- Vaccination to certain individuals at high risk.

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

[7] 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:

- Community transmission outside the main networks of transmission with no identifiable link to another case (no travel history or links);
- Evidence of re-infection or vaccine failure (individual cases of);
- Clear evidence that cases are rising (e.g. consistent increase in weekly average number of cases);
- Clear evidence that community transmission is occurring across wider geographical areas;
- A larger cluster or outbreak (e.g. following a particular event, or with a rapid increase in a short period); and
- 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 confirmed, possible/probable MPXV infection(s), refer to the **IPC Precautions for healthcare workers guidance**.

Confirmed case(s) who do not require hospitalisation for medical management may isolate/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, student residence or dormitory, State-provided congregate accommodation for refugees and applicants seeking protection, hostel, refuge/shelter etc.;
- The nature and extent of lesions in each case;
- Ability 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 individual outside a hospital setting or following discharge of clinically well individuals 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 and Glove Use

- 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;
- Gloves should be worn when cleaning areas or handling items (e.g. bedding, clothing, surfaces) that may be contaminated by someone with mpox;
- Gloves should also be worn when providing direct care to a person with mpox or handling their waste;
- Hand hygiene should always be performed after the removal of gloves; and
- Refer to hand hygiene posters and training material for correct technique, that can be found **here**.

4.2 Transmission Based Precautions

In accordance with **National Irish IPC Guidelines**, other national (*i.e.* **IPC Precautions for healthcare workers guidance**.) and international guidance, initial

management, informed by PCRA should include **airborne, droplet and contact precautions**.[8]

4.2.1 Confirmed/Highly possible/probable Case MPXV

- 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)/appropriately controlled ventilation room 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 they have respiratory symptoms), 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*. **IPC Precautions for healthcare workers guidance**.) and international guidance.

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

Ensure that for all clinical interactions with MPXV cases (i.e. confirmed and probable/possible) that **PPE** is used in line **with IPC Precautions for healthcare workers guidance**. Refer to **Section 1.6** for further details.

[8] Airborne precautions should be implemented as a precautionary measure for the following reasons: until varicella has been out ruled; the extent of the rash and the lesions has been determined; and it has been determined that the patient does not have any upper/lower respiratory tract symptoms.

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 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 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/appropriately controlled ventilation room, 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 a congregate accommodation 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.

4.3 Infection, Prevention and Control

4.3.1 Healthcare Settings

Standard Considerations: For detailed infection prevention and control measures, refer to the guidance document: **Infection Prevention and Control Precautions for Healthcare Workers in the Management of Suspected or Confirmed Mpox (Clade I and Clade II) -** found **here.**

4.3.2 Non-Healthcare Settings

Individuals who do not require hospitalisation for medical management may isolate/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 infection 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. The following factors should be taken into consideration:

- Type of household setting e.g. in the home setting, apartment complex, student residence or dormitory, State-provided congregate accommodation for refugees and applicants seeking protection, hostel, refuge/shelter etc.;
- The nature and extent of lesions in each case;
- Ability 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 dependency factors;
- If an individual is a child or adult; and
- The following principles should be considered and adopted to the greatest extent possible in the household setting.

Hand Hygiene

- Careful hand and respiratory hygiene are recommended for the case and everyone in their household/family unit;
- Hand hygiene (i.e., hand washing with soap and water or use of an alcohol-based hand rub) should be performed by infected persons and household contacts after touching lesion material, clothing, linens, or environmental surfaces that may have had contact with lesion material; and
- Refer to hand hygiene posters and training material for correct technique, that can be found **here**.

Use of Personal Protective Equipment

- All confirmed cases should wear a medical grade 3 (surgical) mask, especially those who have respiratory symptoms (e.g., cough, shortness of breath, sore throat) when they come into close contact (i.e. < 1 metre) with other household contacts. If this is not feasible (e.g., a child with mpox), other household members should be advised to wear a medical grade (surgical) mask when in the presence of the person with mpox.
- The person caring for or supporting the person with mpox should wear disposable gloves for direct contact with lesions and handling soiled personal clothing or linen.
- Skin lesions should be covered (if tolerated) to the best extent possible (e.g., long sleeves, long pants) to minimize risk of contact with others.
- Materials from infected individuals (e.g., dermal crusts) or fomites (e.g., bed linens) are high risk for onward transmission. Gloves and masks should be worn by those changing bed linens and they should be advised not to shake the linen to prevent dispersal of skin scales and virus particles.
- Recommend opening windows to ensure the area is well ventilated (during these activities), bearing in mind the person's comfort.

Laundry

Cleaning of domestic settings should be carried out in the following order

- Contaminated clothing and linens should be collected first before the room is cleaned. Personal clothing or linen items should not be shaken or handled in a manner that may disperse infectious particles
- Items that have been in direct contact with the skin of an infected person and are not easily washed in a domestic washing machine such as duvets, pillows, or blankets, can be placed in a bag and sealed.
- Care should be taken when handling soiled laundry, such as bedding, towels and personal clothing, to avoid direct contact with contaminated material. Disposable gloves should be worn; hands should be cleaned immediately after removing the gloves. This should be undertaken by the confirmed case where possible.
- Place linen in a disposable bag for transfer to the washing machine to avoid dispersal of virus particles and skin scales.
- Contaminated clothing and linens should be washed at 60°C cycles using an extended washing cycle. Do not overload the washing machine (aim for half or two-thirds full) and avoid shorter ‘economy cycles’ (those which reduce water and save energy) until the individual has fully recovered
- Whenever possible, confirmed mpox cases should do their own laundry and keep their laundry items separate from the rest of the household’s laundry and wash them using their normal detergent, following manufacturer’s instructions
- Washed items should not be placed into areas where they may be re-contaminated during the cleaning process
- If an individual does not have a washing machine, they can handwash their laundry using warm water and normal detergent. This might be more effective in a large sink or bathtub. It is important to clean and disinfect all surfaces when finished wearing disposable gloves. Take extra care if using bleach to disinfect these surfaces afterwards.

Laundry in Congregate Settings

In settings where individuals live in close proximity, additional precautions are required:

- Staff handling laundry from mpox cases must wear gloves, aprons, and masks.
- Avoid shaking laundry to prevent aerosolization of virus particles.
- Use a 60°C extended wash cycle with regular detergent. Do not overload machines.
- Clean and disinfect laundry equipment and surrounding surfaces after use.
- Where possible, residents with mpox should manage their own laundry. If not feasible, staff should follow appropriate PPE protocols.
- Clean laundry should be stored separately and not returned to areas where contamination may occur.

Environmental Cleaning

- Carpets, curtains and other soft furnishings can be steam cleaned
- Dishes and other eating utensils should not be shared unless they are properly washed
- Individuals should handle their own used dishes and other eating utensils, and if they have one, use a dishwasher with hot water (over 60°C) and detergent to clean and dry these items. If this is not possible, dishes and other eating utensils should be washed using their usual washing up liquid and warm water and leave them to air dry If an individual has lesions on their hands and no access to a dishwasher, they should be advised to wear single use disposable gloves or reusable washing up gloves while washing up. Any reusable gloves should not be shared and should be discarded at the end of the individual's isolation period.

- Regularly clean frequently touched surfaces, such as door handles and light switches and use a damp cloth to prevent dust from accumulating on surfaces, especially in the bedroom.
- Contaminated surfaces should be cleaned and disinfected. Single-use disposable cleaning cloths are recommended for cleaning surfaces. If single use cloths are not available, wash cloths at the highest temperature possible e.g. at least 60°C cycle.
- Standard household cleaning/disinfectants may be used in accordance with the manufacturer's instructions.
- Particular attention should be paid to the cleaning of toilets and frequently touched surfaces especially if shared by other household contacts.
- Carpets etc. can be cleaned using a HEPA filtered vacuum cleaner (if available); care must be taken when disposing of the vacuum cleaner bag/contents to minimise dispersal of dust particles. Vacuum cleaner waste should be carefully emptied into a disposable rubbish bag.
- Personal waste (such as used tissues) and disposable cleaning cloths can be disposed of in disposable rubbish bags and secured pending collection
- As an additional precaution, all disposable rubbish bags should be placed into a second disposable bag, tied securely, before being disposed of as usual with domestic waste. All rubbish bags should be stored securely until bin collection. Waste should not be put into recycling bins until the period of self-isolation has ended

4.6 Ending self-isolation

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

- Based on Regional 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 infection should have recommended isolation precautions maintained until mpox infection is ruled out; and
- Those with confirmed MPXV 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.
- **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, and lesion criteria sections above are all met.

4.6.3 Discharge from hospital to home

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

Individuals meeting the clinical criteria but not meeting 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 De-isolation in household settings

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 mucosal membrane lesions (e.g. in mouth, rectum)

If all the points above are met, the individual may be able to stop self-isolating but should first 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 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 transmission-based 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

Appropriate **airborne, droplet, and contact precautions** following risk assessment 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. following risk assessment.

5.2 Exposure

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

5.2.1 Defining an exposure

The purpose 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.