NATIONAL AMBULANCE SERVICE
INFECTION PREVENTION & CONTROL GROUP (NASIPCG)

Monkeypox Guidance
POSITION STATEMENT – 11/07/22 (V1.0)
Please note this is a moving situation and further updates may be required.

Latest Update

As of 08/07/22 the UK Health Security Agency (UKHSA) has been notified of over 1,552 confirmed cases of monkeypox within the UK. The latest number of cases can be found here.

In the UK MPX is classed as an airborne high consequence infectious disease (HCID) in healthcare settings. This is not a legal classification but is a highly precautionary approach agreed by UKHSA and NHS programmes prior to the current (2022) incident and when availability of vaccines and treatment options were unconfirmed.

The Advisory Committee on Dangerous Pathogens (ACDP) have considered whether the HCID criteria continues to apply to monkeypox in the context of the current outbreak. ACDP considered the data provided on the UK cases, these have not been severe, and vaccination available/deployed. The committee recommended that the West African Clade MPX strain Lineage B.1 currently in community transmission within the UK should no longer be classified as a HCID. This advice has been published by UKHSA (5/7/22) removing the current 2022 MPX outbreak (West African Clade Lineage B.1) from HCID status. **Error! Hyperlink reference not valid.**

However, any Possible, Probable or Confirmed cases of MPX with a travel history to West or Central Africa, **OR** a link to a traveller from those regions. **OR** with a link to an outbreak which is known to be outside Lineage B.1 or sequenced and known to be outside Lineage B.1 should still to be classed and managed as a HCID.

Transmission in this 2022 MPX outbreak is consistent with close direct contact. There is currently no evidence that individuals are infectious before the onset of the prodromal illness.

Background

The purpose of this document is to provide infection prevention and control (IPC) measures to prevent transmission of monkeypox (MPX) in health and care settings in England. This document should be read in conjunction with the National Infection Prevention and Control Manual (NIPCM) for England specifically appendix 11b, and UKHSA principles for monkeypox control in the UK: 4 nations consensus statement.

Presentation

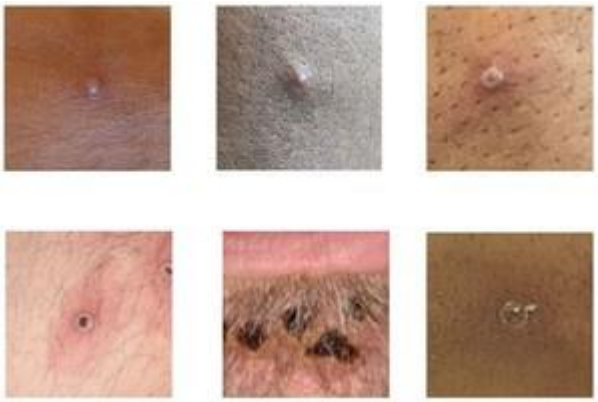
The incubation period of monkeypox is between 5 and 21 days after exposure, usually 6 to 16 days, with an initial clinical presentation of:

- Fever.
- Headache.

- Muscle aches.
- Backache.
- Swollen lymph nodes.
- Chills.
- Exhaustion.

Within 1 to 5 days after the appearance of fever, a rash develops, often beginning on the face or genital area, then spreading to other parts of the body. The rash changes and goes through different stages before finally forming a scab which later falls off. An individual is contagious until all the scabs have fallen off and there is intact skin underneath. The scabs may also contain infectious virus material.

Figure 1 – Images of Monkeypox Rash



In some of the new cases, the rash has presented on genitals and occurred before the fever prodrome.

The rash is sometimes confused with chickenpox. It starts as raised spots, which turn into small blisters filled with fluid. These blisters eventually form scabs which later fall off. The symptoms usually resolve in 2 to 4 weeks.

Transmission

Monkeypox does not spread easily between people. It may occur when a person comes into close contact with an animal (rodents are believed to be the primary animal reservoir for transmission to humans but monkeypox is not found in UK rodents at present), human, or materials contaminated with the virus.

The virus enters the body through broken skin (even if not visible), the respiratory tract, or the mucous membranes (eyes, nose, or mouth). Person-to-person spread is uncommon, but may occur through:

- Contact with clothing or linen (such as bedding or towels) used by an infected person.
- Direct contact with monkeypox skin lesions or scabs.
- Coughing or sneezing of an individual with a monkeypox rash.

It is not a sexually transmitted disease but may be spread by close skin contact during sexual activity.

Infection Prevention and Control

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.

Frontline and other operational ambulance resources may transport these patients. HART (Hazardous Area Response Team) should not be used for these transfers, but must be considered for any Monkeypox cases that fall outside the current outbreak clade.
These principles do not replace the need for local dynamic risk assessments which remain key.
Based on the level of exposure and risk assessment consideration of the hierarchy of controls will help determine the level of personal protective equipment (PPE) to use.

For any individual presenting in person for advice/treatment, an infection risk assessment requires clinical judgement to identify the risk of cross transmission based on the presenting case/operational definition of MPX as defined UKHSA 5th July (link below), and the PPE required:

Monkeypox:

i. Without travel to West or Central Africa and without a link to a traveller from those regions

AND/OR

ii. Confirmed by sequencing to be within the current outbreak clade (Lineage B.1)

is NOT considered a high consequence infectious disease.

Monkeypox:

i. With a travel history to West or Central Africa, a link to a traveller from those regions

OR

ii. With a link to an outbreak which is known to be outside Lineage B.1 OR iii. sequenced and known to be outside Lineage B.1 OR iv. which results from a new zoonotic jump in any country or setting.

is considered a high consequence infectious disease.

PPE requirements will differ based on clinical judgement to include:

- the operational/ case definition and whether the case is considered a HCID
- the individual's presenting symptoms if presenting with an unexplained rash or other symptoms such as disseminated lesions or deteriorating condition resulting in a clinical suspicion of MPX
- presence of respiratory symptoms / disseminated lesions or if the patients condition is deteriorating
- the clinical procedures being undertaken e.g. prolonged clinical contact within 1 metre.

Table 1:Minimum PPE requirements for possible, probable and confirmed MPX cases

Case groups	**MINIMUM PPE required**
Cases NOT considered as high consequence infectious disease. Possible, Probable and Confirmed MPX. Without travel to West or Central Africa and without a link to a traveller from those regions and/or confirmed by sequencing to be within the current outbreak clade (Lineage B.1) **AND**	• Disposable gloves – single pair • Fluid Resistant surgical facemask (FRSM – Type IIR): • An Apron

Where symptomatology is limited to a rash and patient is generally well – **NO respiratory symptoms.**	• Face/eye protection (if there is a risk of spraying/splashing)
Possible, Probable and Confirmed MPX Where symptomatology **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, for example inpatient care or repeated assessment of an individual who is clinically unwell or deteriorating	• An FFP3 respirator[1] (fit-tested and fit-checked) or equivalent e.g. powered air purifying respirator (PAPR)[1] rather than FRSM • Disposable gloves • A disposable, fluid-resistant gown (coveralls may be worn in some settings e.g. ambulance) • A full face visor[1]
Cases considered as high consequence infectious disease Possible, Probable or Confirmed cases of MPX with a travel history to West or Central Africa, **OR** a link to a traveller from those regions. **OR** with a link to an outbreak which is known to be outside Lineage B.1 or sequenced and known to be outside Lineage B.1 **OR** which results from a new zoonotic jump in any country or setting.	**TREAT AS HCID – FULL HCID PPE ENSEMBLE**

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

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

Guidance for safe donning and doffing of PPE is available in the NIPCM appendix 6.

All possible, probable and confirmed cases of MPX should be provided with a facemask (type II or type IIR) in all healthcare settings to be worn for the duration of the treatment/consultation/transport unless removed for clinical assessment/treatment.

Waste including PPE:

All waste generated in the care of possible, probable, or confirmed MPX cases must be managed as category B waste. Refer to the Department for Transport Multilateral Agreement M347 under section 1.5.1 of ADR on the carriage of monkeypox virus (see UKHSA guidance)– applicable to ALL clades of MPX until 2025.

Advice can be sought from the local waste contractor, a Dangerous Goods Safety Adviser, or in Health Technical Memorandum 07:01 'Safe Management of Healthcare Waste'.

Linen:

All linen generated in the care of possible, probable, or confirmed MPX must be managed as infectious linen and bagged into a water soluble or soluble seam (alginate) bag then placed into a polythene bag or impermeable sack.

Decontamination

- Following convey of a possible case; carefully clean all equipment and vehicle environment with combined detergent/disinfectant wipe wipes and allow to air dry.

- For the convey of a highly probable (displaying extensive symptoms including weeping pustules and respiratory symptoms) or confirmed cases, vehicles must be initially cleaned using a detergent/disinfect wipe followed by a solution of 1,000ppm av.cl. (or alternative locally agreed cleaning product).

- PPE for cleaning should match the level of PPE for clinical patient care.

Discharge of patients: Advice outlined in this document on safe working practices apply. Ambulance services should follow ambulance standard operating procedures for managing infectious individuals (including HCIDs).

Patient discharges by an organisations PTS provider will be undertaken in a suitable vehicle and ensuring:

- the patient does not share the transport with other patients
- the patient lesions are covered if visible (face/hands) wherever possible
- the patient wears ans FRSM (if tolerated)
- the patient is physically separated from the driver.
- Staff undertaking the transfer are wearing appropriate PPE as per table 1
- the vehicle must be decontaminated after each discharge /transfer following agreed local SOP (terminal clean) using:
    - a combined detergent disinfectant solution at a dilution (1,000ppm av.cl.); or
    - a general-purpose neutral detergent in warm water followed by a solution of 1,000ppm av.cl. (or alternative locally agreed cleaning product)

Further information and guidance can be found on UKHSA and NHSE websites. If you have any questions please speak to your trust IPC lead.

Ref:

IPC measures for possible probable anc

https://www.gov.uk/government/publications/principles-for-monkeypox-control-in-the-uk-4-nations-consensus-statement -updated 5th July 2022

https://www.gov.uk/guidance/hcid-status-of-monkeypox,

C1636-national-ipc-manual-for-england-v2.pdf