

Infection Prevention and Control Guidance for Healthcare Settings in Northern Ireland

Mpox: Management of suspected or confirmed cases.

1st May 2025

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

Version History

Version	Date	Summary of changes
V1.0	30th June 2023	First publication – information relating to non-HCID Mpox only.
V1.1	12 th September 2024	This update was made in response to the outbreak of Clade I mpox in the African Region, which the World Health Organization declared a public health emergency of international concern. The update includes Clade I as a High-Consequence Infectious Disease (HCID).
V1.2	5 th November 2024	Updated following identification of Clade I mpox cases in the UK and revision of case definitions by UKHSA.
V1.3	1 st May 2025	As of 19th March 2025, Clade I (a&b) have now been derogated by ACDP/UKHSA as non HCID

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1. Purpose and Scope

This document outlines the infection prevention and control advice for healthcare workers who may be involved in the care of suspected or confirmed cases of mpox.

The guidance is based on the published [Principles for control of non-HCID mpox in the UK: 4 nations consensus statement](#) from the UK Health Security Agency (UKHSA) and associated [UKHSA Mpox guidance](#) and should be read in conjunction with the relevant sections of the Northern Ireland Regional Infection Control Manual (<https://www.niinfectioncontrolmanual.net/>), which provides general guidance on infection prevention and control.

2. Background

Mpox is caused by the monkeypox virus (MPXV). It is an enveloped double-stranded DNA virus of the *Orthopoxvirus* genus in the *Poxviridae* family, which includes variola, cowpox, vaccinia and other viruses. There are 2 major genetic groups (clades) of MPXV: Clade I (formerly known as Central African or Congo basin clade), which has a reported increased mortality rate, and Clade II (formerly known as West African clade). Sub-types of each clade have been identified. Clade I is split into clade Ia and clade Ib. Clade II is split into clade IIa and clade IIb.

The first case of Clade I MPXV was identified in the United Kingdom (UK) in October 2024, overall risk of Clade I MPXV to the UK population is still considered low to medium.

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

The latest epidemiological data on mpox (all clades) can be found on the [World Health Organization \(WHO\) mpox surveillance dashboard](#).

The Advisory Committee on Dangerous Pathogens (ACDP) recently assessed evidence gathered by UKHSA for clade I mpox and advised that it no longer met the criteria of a high consequence infectious disease (HCID). Mpox remains a serious infection for some individuals and remains a World Health Organization (WHO) public health emergency of international concern (PHEIC).

3. General Information

Mpox is an infectious disease that is caused by infection with a virus called MPXV. Mpox was first discovered in 1958 when outbreaks of a pox-like disease occurred in monkeys kept for research. The first human case was recorded in 1970 in the Democratic Republic of the Congo (DRC), and since then, the infection has been reported in several African countries. Before 2022, most cases were reported from the DRC and Nigeria. The incubation period is the duration/time between contact with the person with mpox and the time that the first symptoms appear. The incubation period for mpox is between 5 and 21 days.

Mpox infection is usually a self-limiting illness, and most people recover within several weeks. However, severe illness can occur in some individuals. The illness typically begins with:

- fever
- headache
- muscle aches
- backache
- swollen lymph nodes
- chills
- exhaustion
- joint pain

However, not all people who have mpox experience all of these symptoms. Within 1 to 5 days after the appearance of fever, a rash develops, often beginning on the face and then spreading to other parts of the body, including the soles of the feet and palms of the hands. Lesions can also affect the mouth, genitals and anus. The rash changes and goes through different stages before finally forming scabs which eventually fall off.

Some individuals may not have a widespread rash, and in some cases, only genital lesions are present. These may be blisters/vesicles, scabs or ulcers.

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.

Transmission

Mpox does not spread easily between people unless there is close contact.

Spread between people may occur through:

- direct contact with rash, skin lesions or scabs (including during sexual contact, kissing, cuddling or other skin-to-skin contact)
- contact with bodily fluids such as saliva, snot or mucous
- contact with clothing or linens (such as bedding or towels) or other objects and surfaces used by someone with mpox

It is possible that mpox may spread between people through close and prolonged face-to-face contact such as talking, breathing, coughing, or sneezing close to one another. However, there is currently limited evidence so this will be updated as new information is available.

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

Case definition

It is important that IPC precautions and pathways are in place for any suspected Mpox case while investigations are being undertaken.

Consider mpox where a case presents with:

1. a prodrome (fever, chills, headache, exhaustion, myalgia, arthralgia, backache, lymphadenopathy), and where there is known prior contact with a confirmed or suspected case of mpox in the 21 days before symptom onset

Or:

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

- recent new sexual partner
- contact with known or suspected case of mpox
- a travel history to a [country where mpox is currently common](#)
- link to an infected animal or meat

4. Patient Management

If the rash is highly clinically suggestive of mpox, but you cannot identify a risk factor, discuss with local infection specialists whether to consider mpox testing alongside the more common differential diagnosis.

Consider common infections such as chickenpox or shingles, herpes simplex virus, and enterovirus in the differential diagnosis; these circulate widely and are more common than mpox; exclude as appropriate.

4.1 Patient Placement

Risk assessments using the [hierarchy of controls](#) must be conducted in all areas where there is a possibility of encountering or caring for individuals with clinically suspected or confirmed cases of mpox. These assessments should be carried out by a competent person who has the necessary skills, knowledge and experience to identify and manage the risks associated with mpox. Every effort should be made to perform telephone triage/assessment to help establish symptoms present and risk associated with potential mpox in advance of any face-to-face contact where possible.

If an individual arrives at any healthcare facility for treatment of an unexplained rash or symptoms/ history consistent with suspected Mpox they should also immediately be isolated and triaged and managed with [transmission-based precautions \(TBP's\)](#) until assessed by the clinician. If Mpox infection is suspected from initial case investigation in secondary care, the patient should be isolated in a negative-pressure single room with dedicated medical and patient care equipment, or as a minimum a single room with en-suite facilities separated from vulnerable patients. Inform the local Infection Prevention and Control team without delay. Staff at reception points should have a heightened awareness of Mpox and associated definitions especially travel history when booking in patients to ensure they can rapidly inform clinical staff so that triage and isolation is expedited without delays.

In primary care settings, suspected cases should be isolated in a side room with a closed door. Advice should be sought from the local health protection/infection prevention and control teams, including transfer to secondary care and immediate precautions.

Inpatients are not required to wear a Fluid Resistant Surgical Mask (FRSM) while in a single or isolation room. However, patients with suspected or confirmed mpox moving between care areas should be provided with a FRSM to wear - where this can be tolerated and does not compromise their clinical care, for example when receiving oxygen therapy.

4.2 Personal Protective Equipment

The requirement and level of PPE depends on the application of workplace assessments based on the Hierarchy of Controls as above (section 4.1).

Table 1 below outlines the PPE requirements for suspected or confirmed Mpox.

Table 1

Definition categories	Minimum PPE required
<p>Mpox virus (MPXV): Suspected cases</p> <p>Prodrome, rash (localised or widespread), lesions, with no respiratory symptoms</p>	<ul style="list-style-type: none"> ➤ Gloves – single pair. Ensure hand hygiene is performed appropriately before and after removal of gloves ➤ Fluid Resistant Surgical Facemask (FRSM) ➤ Plastic apron (or long-sleeved fluid resistant gown where extensive manual handling or unavoidable skin to skin contact is required) ➤ A visor/eye protection should be considered if there is a risk of spraying/splashing of blood or bodily fluids
<p>Mpox virus (MPXV): Suspected cases</p> <p>Prodrome, rash (localised or widespread), lesions, with respiratory symptoms</p>	<ul style="list-style-type: none"> ➤ Gloves – single pair. Ensure hand hygiene is performed appropriately before and after removal of gloves ➤ An FFP3 respirator (fit tested and fit checked) or equivalent respiratory protection (e.g. hood or powered air respirator) ➤ Disposable, fluid resistant long-sleeved gown ➤ A visor/eye protection should be considered if there is a risk of spraying/splashing of blood or bodily fluids

<p>Mpox virus (MPXV): Confirmed cases</p>	<ul style="list-style-type: none"> ➤ Gloves – single pair. Ensure hand hygiene is performed appropriately before and after removal of gloves ➤ An FFP3 respirator (fit tested and fit checked) or equivalent respiratory protection (e.g. hood or powered air respirator) ➤ Disposable, fluid resistant long-sleeved gown ➤ A visor/eye protection should be considered if there is a risk of spraying/splashing of blood or bodily fluids
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4.3 Decontamination

Staff responsible for decontamination of healthcare environments where clinically suspected or confirmed mpox cases are managed must be properly trained in the correct use of all products and the necessary PPE. Equipment in the room where a suspected or confirmed case of mpox is being managed should be kept to a minimum. Reusable patient care equipment should be dedicated to the patient as far as practicable. Please see Decontamination guidance on [NI Infection Control Manual](#). Cleaning and decontamination of the patient room within healthcare settings should be undertaken using:

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

Manufacturers' guidance and recommended product "contact time" must be followed for all cleaning/disinfection solutions. Increased frequency of decontamination/cleaning schedules should be incorporated into the environmental decontamination schedules for rooms occupied by suspected or confirmed cases.

Inpatient rooms must be terminally cleaned following discharge, transfer or when the suspected or confirmed mpox case is deemed no longer infectious.

4.4 Waste

According to the international agreement, waste and samples from individuals suspected or confirmed to have mpox should be treated as healthcare (clinical) Category B waste. This waste can be disposed of in an orange bag for alternative treatment and does not require incineration. It is classified under UN 3291 as clinical waste. If the waste contains chemical or pharmaceutical contaminants, it must be placed in a yellow container (or purple if cytotoxic or cytostatic), and either incinerated or sent to a permitted site for disposal as per national regulation. Further information on waste management can be found in the [NI Infection Control Manual](#).

Laboratory cultures of MPXV remain classified as Category A.

4.5 Linen

Contaminated clothing and linen are a potential source of transmission. Care must be taken to lift and roll the linen gently at the bedside, not shake the linen to prevent the dispersal of skin scales. All linen generated during the care of a suspected or confirmed case of mpox must be managed as infectious linen. Please see the guidance in the [NI Infection Control Manual](#). Ideally, infectious linen should be stored securely until diagnostic results are available.

References:

- [NI Infection Control Manual](#)
- [Mpox: guidance - GOV.UK](#)
- [Biological principles for control of mpox in the UK: 4 nations consensus statement - GOV.UK](#)