Salisbury NHS Foundation Trust

SFT Monkeypox Response Plan

Type of document
Please tick the relevant box:

Policy (must do) ☐

Guidance (should do) ☐

Protocol/procedure (must do) ☑

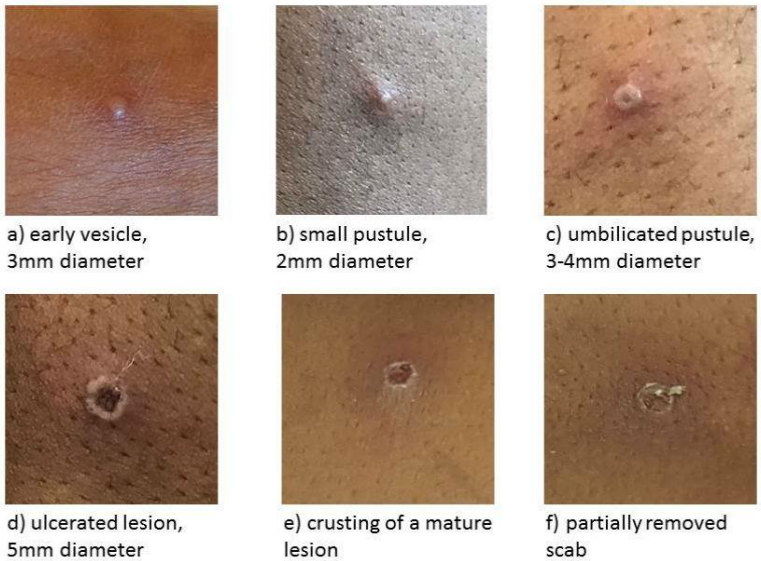
Responsible for guidance:	Deputy Chief Nurse, Consultant Microbiologists and EPRR
iRespond cards:	03.203 V3.0 03.204 V5.0 03.205 V3.0 03.206a V2.0 03.206b V2.0 03.207 V2.0 **Intentionally Removed:** None
Date revised:	26th October 2022
Overarching collated document version:	Version 5.0

Title:	**Monkeypox – Background information**	**Serial Number: 03.203**	
Owner:	Consultant Microbiologists, Deputy Chief Nurse & EPRR		
Version:	3.0	**Date: Oct 2022**	**Review: Oct 2024**

Purpose	To provide background for a suspected case of Monkeypox.
Background	Monkeypox is a rare disease that is caused by infection with monkeypox virus and is classed as a high consequence infectious disease (HCID). The current UK outbreak has now been reclassified as no longer being a HCID in a communication from NHSE on the 6th July 2022. However, the NHSE update advised any new national outbreak would reach the criteria to be classified as a HCID
Epidemiology	Monkeypox is a rare disease that is caused by infection with monkeypox virus. Monkeypox 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 a number of central and western African countries. Most cases are reported from the DRC and Nigeria.
Possible Cases	A person with a febrile prodrome compatible with monkeypox infection where there is known prior contact with a confirmed case in the 21 days before symptom onset. Or, a person with an illness where the clinician has a high suspicion of monkeypox (for example, this may include prodrome or atypical presentations with exposure histories deemed high risk by the clinician, or classical rash without risk factors). Febrile prodrome consists of fever ≥ 38°C, chills, headache, exhaustion, muscle aches (myalgia), joint pain (arthralgia), backache, and swollen lymph nodes (lymphadenopathy).
Probable Cases	A person with a monkeypox compatible vesicular-pustular rash plus at least one of the following epidemiological criteria: • exposure to a confirmed or probable case in the 21 days before symptom onset • history of travel to an area where monkeypox is endemic, or where there is a current outbreak in the 21 days before symptom onset (currently West and Central Africa) • gay, bisexual and other men who have sex with men (GBMSM) https://www.gov.uk/guidance/monkeypox-case-definitions?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=df31b726-2d0b-43bb-9477-faa7a85cac46&utm_content=daily
Transmission	Monkeypox does not spread easily between people. Spread of monkeypox may 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), human, or materials contaminated with the virus. Monkeypox has not been detected in animals in the UK. 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 linens (such as bedding or towels) used by an infected person • direct contact with monkeypox skin lesions or scabs (including body fluids

	or lesion material) • coughing or sneezing of an individual with a monkeypox rash

Title:	**Monkeypox – Clinical Response**	**Serial Number: 03.204**	
Owner:	Consultant Microbiologist, Deputy Chief Nurse & EPRR		
Version:	5.0	**Date: 10th October 2022**	**Review: Oct 2023**

Purpose	To provide an action card for the clinical response to a suspected case of Monkeypox
Clinical Feature	The incubation period is the duration/time between contact with the infected person and the time that the first symptoms appear. The incubation period for monkeypox is between 5 and 21 days. Monkeypox infection is usually a self-limiting illness and most people recover within several weeks. However, severe illness can occur in some individuals. The illness begins with: • 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 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.  a) early vesicle, 3mm diameter b) small pustule, 2mm diameter c) umbilicated pustule, 3-4mm diameter d) ulcerated lesion, 5mm diameter e) crusting of a mature lesion f) partially removed scab Images of monkeypox lesions • Areas of erythema and/or skin hyperpigmentation are often seen around discrete lesions. • Lesions can vary in size and may be larger than those shown. • Lesions of different appearances and stages may be seen at the same point in time. • Detached scabs may be considerably smaller than the original lesion.

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Triage Questions to consider	Have you got 1 or more of the following symptoms: • Rash on any part of your body • Fever • New lumps/s in neck, groin or under your arm If Yes, ask the below further questions: • Are you gay, bisexual, or other MSM? • Have you had contact with someone with confirmed monkeypox in the 21 days prior to symptom onset? • Have you travelled to West or Central Africa in the 21 days prior to symptom onset?
Isolation	Use of the ED decontamination room as per our Viral Haemorrhagic Fever (VHF) protocols for isolation or for patients not presenting at ED e.g. AMU/SAU/Paeds/Sexual Health isolate in a single room or side room facility For any patients who require carers the carer must remain in the side room with patient until further advice is sought
Diagnosis	Clinical diagnosis of monkeypox can be difficult, and it is often confused with other infections such as chickenpox. A definite diagnosis of monkeypox requires assessment by a health professional and specific testing in a specialist laboratory. In the UK, the Rare and Imported Pathogens Laboratory (RIPL) at the UK Health Security Agency (UKHSA) Porton Down is the designated diagnostic laboratory. Suspected cases should be discussed with the on call microbiologist or Imported Fever Service prior to submitting samples for laboratory testing.
Swabbing a clinically suspected patient	If a case of monkey pox is suspected clinically due to the above clinical features or the patient is a contact of a confirmed case, then the following actions should be followed 1. Nurse patient in a single room ideally with own toilet/bathroom and keep the door shut (if presenting at ED – potentially use the decontamination unit as per our VHF protocol) 2. Staff assessing patient should wear the following disposable PPE: FFP3 disposable mask, eye protection, gloves and long-sleeved water repellent gown 3. If Monkeypox is suspected clinically then please phone the on call microbiologist or the Imported Fever Service on 0844 778 8990 who will give appropriate advice on sampling Imported fever service (IFS) - GOV.UK (www.gov.uk) 4. Usually, a swab of a lesion is performed using a swab in viral transport medium (green or red topped swab) 5. Double bag the sample and leave in the COVID testing box on level 3 6. Phone the Consultant microbiologist to inform them that a sample has been collected. Further advice may also be given by the microbiologist if necessary

	although this would usually be done by the Imported Fever Service Above 7. The microbiologist should then inform the Deputy COO ext: 4437, Head of Patient Flow ext: 5540 and Head of EPRR ext: 5699 in hours and the Duty Manager via main switchboard out of hours of a possible case and inform the local public health team 8. Any further queries should be directed to the microbiologist e.g., advice on allowing patient to be discharged home safely, who may then discuss with the Imported Fever Service and local public Health 9. If the patient is being discharged home, then there is no relative urgency with the test result and the sample can be sent to Porton in normal working hours when the staff pick up the sample from the COVID testing box on Level 3. The Microbiologist will be informed of the results and will notify the patient. 10. If the patient needs to stay in either due to clinical need or because the fever service has advised this then the sample needs to be sent urgently to Porton to enable it to be done on the 9am run each day 11. If the patient is to remain an inpatient, then the on-call microbiologist will instruct the on-call microbiology BMS to come in and send the sample via taxi to Porton out of hours 12. Any positive result will be communicated by Porton staff to the Consultant Microbiologist. Please do not phone to chase results. They will be communicated when available and chased up appropriately by the microbiology team if necessary 13. On receipt of results whether negative or positive Microbiologist to inform Deputy COO ext: 4437, Head of Patient Flow ext: 5540 and Head of EPRR ext: 5699 in hours and the Duty Manager via main switchboard out of hours 14. If a positive result, refer to the links below which details the national risk stratification for the patient category types Virtual management of confirmed Monkeypox cases – B1692 dated 21st June V1.0 B1692-virtual-management-of-confirmed-monkeypox-cases.pdf (england.nhs.uk) Management of laboratory confirmed monkeypox infections – B1754 dated 21st June V2.0 B1754_monkeypox-risk-stratification-tool_V2.pdf (england.nhs.uk)
Testing and Reporting by Clinician	All suspected cases must be reported to UK HSA South West Health Protection team Email: swhpt@phe.gov.uk Telephone: 0300 303 8162 (option 1, then option 1) Out of hours advice: 0300 303 8162 (option 1)

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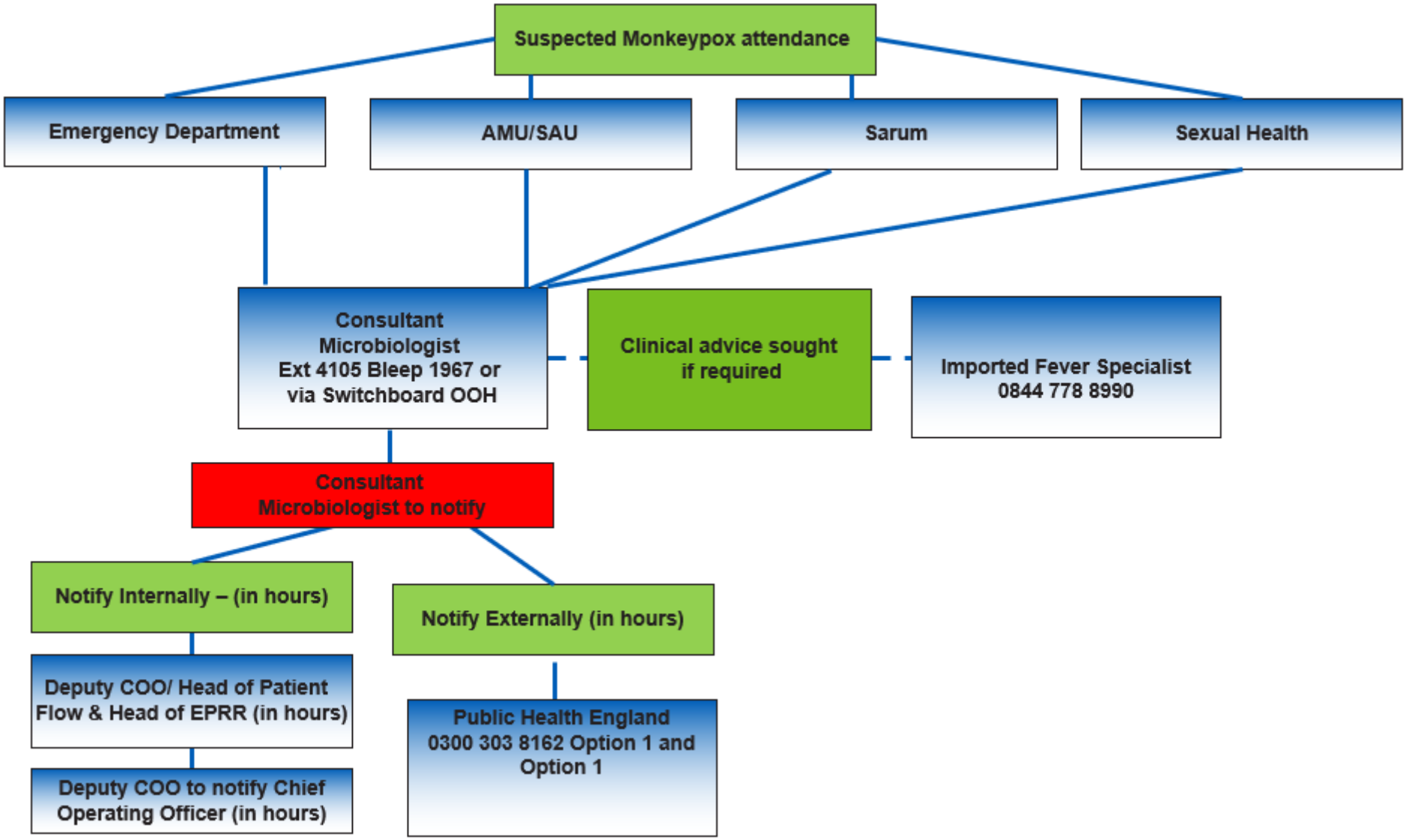
Samples	Microbiology will arrange for the swabs to be processed at Porton Down. Samples received prior to 09.00hrs at Porton will receive the results the same day. Samples are Category 2 and can be transported via courier or DX which is arranged via Microbiology. Any sample received by Microbiology prior to 15.00hrs will go via DX at 16.00hrs.
Waste	Any waste generated from a known or suspected monkeypox patient should be dealt with as Category B waste.
Post exposure prophylaxis	The smallpox vaccine (Imvanex) is the recommended vaccine for post-exposure prophylaxis against monkeypox in the UK. The vaccine is most effective if given within 4 days of exposure but it can be given up to 14 days post-exposure if required. The vaccination will be a process managed outside of SFT, at designated centres. See link to latest national guidance for further information: Monkeypox contact tracing guidance: classification of contacts and advice for vaccination and follow up (publishing.service.gov.uk)

Title:	**Monkeypox – PPE, decontamination and waste**	**Serial Number: 03.205**	
Owner:	Consultant Microbiologists, Deputy Chief Nurse & EPRR		
Version:	3.0	**Date: 11th October 2022**	**Review: Oct 2024**

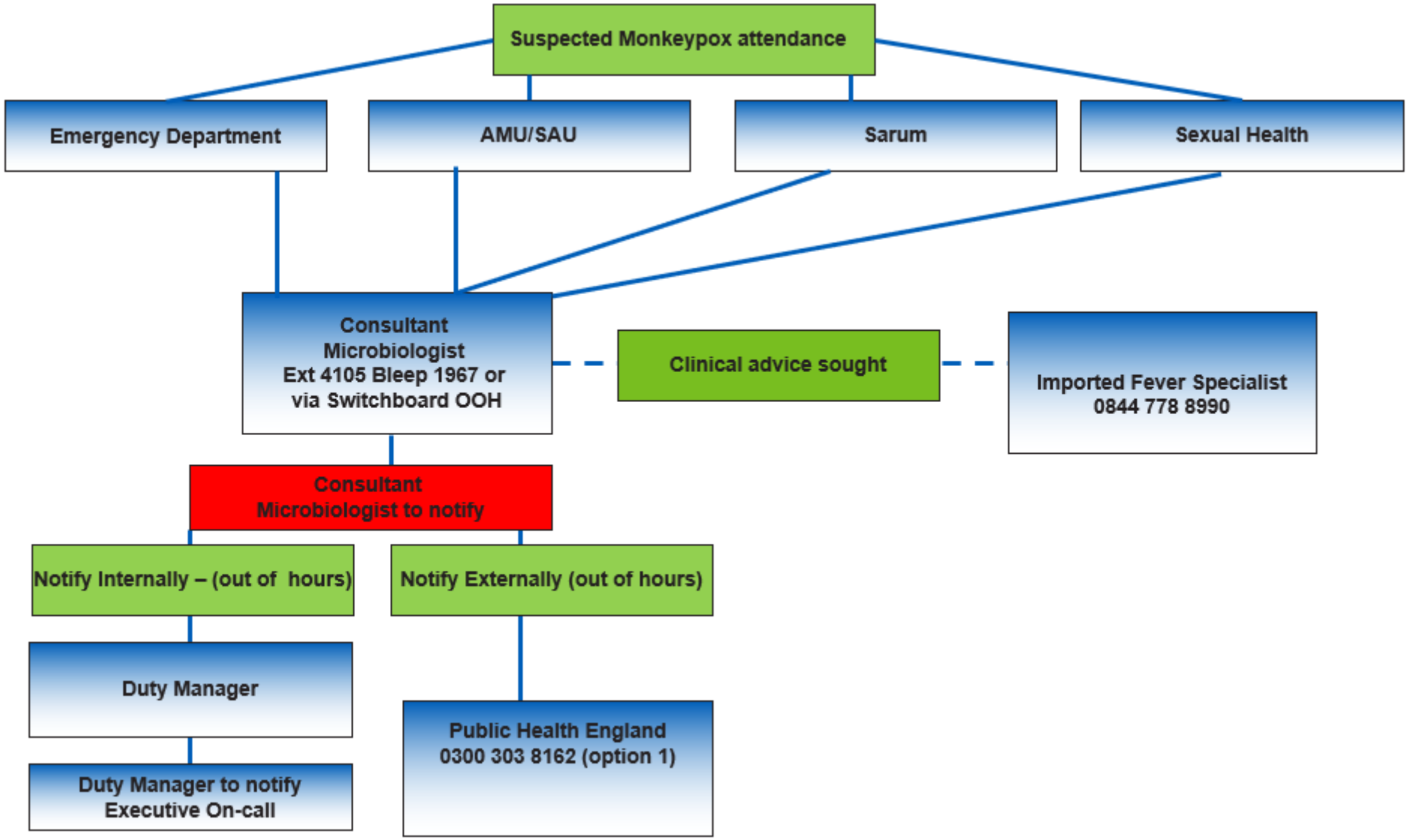
Purpose	To provide an action card to respond to a suspected case of Monkeypox in relation to PPE, decontamination, and waste
Background	Monkeypox is a rare disease that is caused by infection with monkeypox virus and while the current UK outbreak has been stepped down from being classified as a High consequence infectious disease (HCID) the management of the PPE and waste remains the same as if it remained a HCID
PPE	Staff caring for and examining the patient must wear the following disposable PPE • FFP3 respirator mask • Long-sleeved water repellent gown • Gloves • Eye protection • All PPE to be disposable Optimal placement Care setting should be single side room with a en-suite bathroom and ideally negative pressure For further information refer to The principles for monkey pox control in the UK : 4 nations consensus statement Principles for monkeypox control in the UK: 4 nations consensus statement - GOV.UK (www.gov.uk) chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.england.nhs.uk/wp-content/uploads/2022/04/C1636-national-ipc-manual-for-england-v2.pdf
Portering & PPE	Members of the Portering team who transfer clinically suspected patients for diagnostics will be required to wear Level 1 PPE apron and gloves, and normal cleaning processes of wheelchairs as per Trust policy
Linen	Any linen, patient gowns or scrubs that may have been used in caring for Monkeypox patient is to be treated as infected linen • Potentially infected linen should not be shaken or handled in a manner that may disperse infectious particles prior to bagging. • All these items should be placed in a fully dissolvable water soluble (alginate) red bag, sealed or tied and placed inside an impermeable white SLS branded bag and sent to the laundry for processing. • Bags to be only 3/4 full. • Do Not throw away any linen, please bag all items and return to the laundry for processing. Linen should never be disposed of via any other waste stream.
Decontamination	Decontamination of equipment and general environmental cleaning must be performed using either: • A combined detergent/disinfectant solution at a dilution of 1,000 parts per million (ppm) available chlorine (av.cl.); (e.g. Actichlor plus, SoChlor DST, Chlor-clean, Titan Chlor Plus) **or** • A general-purpose neutral detergent in a solution of warm water or

	universal sanitising wipes (e.g. Clinell wipes) followed by a disinfectant solution of 1,000ppm available chlorine (e.g. Actichlor • Rinse all equipment using a damp cloth after either of the decontamination options above as per existing decontamination guidance. Staff to wear full disposable personal protective equipment (PPE). This includes a FFP3 disposable mask, a long-sleeved water repellent gown, gloves, eye protection and shoe covers. All waste including paper towels and PPE must be disposed of as clinical waste (orange coloured bag).
Waste	Any waste generated from a known or suspected monkeypox patient should be dealt with as Category B waste.
Post exposure prophylaxis	The smallpox vaccine (Imvanex) is the recommended vaccine for post-exposure prophylaxis against monkeypox in the UK. The vaccine is most effective if given within 4 days of exposure but it can be given up to 14 days post-exposure if required. The vaccination will be a process managed outside of SFT, at designated centres. See link to latest national guidance for further information: Monkeypox contact tracing guidance: classification of contacts and advice for vaccination and follow up (publishing.service.gov.uk)

Title:	Monkeypox – Communication Channels In Hours	Serial Number: 03.206A	
Owner:	Head of EPRR, Deputy Chief Nurse		
Version:	2.0	Date: 16th June 2022	Review: June 2024



Title:	Monkeypox – Communication Channels Out of Hours	Serial Number: 03.206B	
Owner:	Head of EPRR, Deputy Chief Nurse		
Version:	2.0	Date: 16th June 2022	Review: June 2024



Title:	**Monkeypox – De-isolation and discharge**	**Serial Number: 03.207**	
Owner:	Consultant Microbiologists, Deputy Chief Nurse & EPRR		
Version:	2.0	**Date: Oct 2022**	**Review: Oct 2024**

Purpose	To provide an action card to respond to a suspected case of Monkeypox in relation to isolation and discharge from the interim MPXV deisolation guidance issued 28th May 2022 @ 14.12.Updated on the 21st September 2022 ***Please note: This guidance has not been formally approved but Dr.Susan Hopkins (CMA, UKHSA) has agreed that this can be shared with NHS and HPTs to assist with weekend decision-making.***
1.Scope	This interim guidance has been produced by the UK Health Security Agency (UKHSA) to support NHS Trusts in managing the de-isolation and discharge of monkeypox infected patients. Arrangements for individual patients should be considered on a case-by-case basis. This guidance will be updated in due course.
2. De-isolation criteria	**2.1 Clinical criteria** The patient is judged clinically well enough for safe de-isolation as judged by the clinical team managing the patient. **2.2 Laboratory criteria** The patient is Polymerase Chain Reaction (PCR) negative on all 3 of the following samples: • EDTA blood* • urine • throat swab *It is acceptable not to send EDTA blood if no sample was sent previously because the patient was well throughout admission. 2.3 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 crusted over, all scabs have dropped off, and intact skin remains underneath
3. Discharge from an isolation facility or isolation ward to another hospital ward, a different in-patient facility or a residential facility (including care homes and prisons)	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 2.1, 2.2. and 2.3 are all met. If there is any doubt, clinicians should discuss virological testing of persistent lesions with the UKHSA Rare and Imported Pathogens Laboratory (RIPL). Transfer of patients from an isolation unit in one hospital to an isolation unit in another hospital may be necessary in certain circumstances prior to the patient meeting all of the above criteria. Such arrangements must be made following case-by-case discussion and agreement between specialists at both institutions.
4. Discharge from hospital to home	Patients meeting the clinical, laboratory and lesion criteria as stated in 2.1, 2.2 and 2.3 can be discharged from hospital to home without requirement for ongoing isolation (that is, full de-isolation). Patients meeting the clinical criteria (2.1) but not meeting either laboratory (2.2) or lesion (2.3) 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: children aged under 12, pregnant women or immunosuppressed individuals. They must not go to work, school or public areas and should avoid close contact with other people in their household. Patients with any lesions should remain in regular contact with their clinician until all lesions have crusted 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. **4.1 Caring for monkeypox at home** Patients should be given clear safety-netting guidance, including resources detailing what expected symptoms are and how to treat these. They should also map out what the concerning symptoms to look out for are, and when, where and how to escalate and get help at all time periods. Symptom diaries and strategies for monitoring progress and recovery should also be shared, including where appropriate monitoring tools, for example thermometers, oximeters.
5. De-isolation in household settings	This guidance relates to patients who have been either diagnosed and managed at home throughout their illness, or who have been discharged from hospital to isolate at home. There are 2 stages to de-isolation of patients in household settings. **Stage 1: Ending self-isolation** Patients are able to end self-isolation at home once the following clinical and lesion criteria have been met. **5.1 Clinical criteria** The patient has been assessed by telephone or video call and has been afebrile for 72 hours and is considered systemically well. **6. Lesion criteria** The following criteria must all be met: • there have been no new lesions for 48 hours • there are no oral mucous membrane lesions • all lesions have crusted over • all lesions on exposed skin (including the face, arms and hands) have scabbed over, the scabs have dropped off, and a fresh layer of skin has formed underneath • lesions in other areas should remain covered throughout the patient's time outside of their home or when in contact with other people Patients should continue to avoid close contact with immunosuppressed people, pregnant women, and children aged under 12 until the criteria for full de-isolation are met (see stage 2 below). This means patients should continue to be excluded from work if their work requires close contact with any of these groups. People should also be excluded from work if they work in a vulnerable setting such as healthcare facilities, prisons, care homes, or other care facilities. Stage 2: Full de-isolation The patient can resume full normal activities with no restrictions when they meet the clinical and lesion criteria outlined in sections 2.1 and 2.3 above.