HOMES AND SENIOR SERVICES

POLICY & PROCEDURE NUMBER: 4.28

DEPARTMENT:

POLICY: *Monkeypox (Orthopoxviruses)*

APPROVAL DATE: November 2022

REVISION DATE:

POLICY:

Monkeypox is a viral zoonosis with a typical incubation period of 6 to 13 days (range = 5 to 21 days). Person-to-person transmission of monkeypox occurs via close contact with lesions, body fluids, respiratory secretions and materials contaminated with monkeypox virus. Monkeypox infection may be severe in certain individuals, such as those with immunosuppression.

PROCEDURE:

Prevention:

Vaccinations:

o PHUs are encouraged to support MPX vaccinations for those eligible to receive the vaccine in collaboration with relevant health system partners.

o All clients/residents, staff, and visitors should be encouraged to get vaccinated against MPX if they are eligible to receive the vaccine. See Monkeypox Vaccine (Imvamune®) Guidance for Health Care Providers (gov.on.ca) (2022, or as current) for eligibility criteria.

Transmission:

- Available evidence suggests that those who are most at risk are those who have had close physical contact with someone with monkeypox while they are symptomatic.
  - Contact of non-intact skin or mucous membranes with the body fluids, infectious rash, lesions or scabs of an infected person, or by touching items or surfaces (e.g., bedding or clothing) contaminated with the virus.
  - Respiratory tract secretions (e.g., saliva, respiratory droplets) during direct and prolonged face-to-face contact, or during intimate physical contact. Transmission via short-range aerosols may theoretically be possible; however, transmission during the current global outbreak is believed to primarily be occurring via contact with lesions and their fluid, often through intimate/sexual contact.

Clinical Presentation and symptoms:

Monkeypox closely resembles smallpox clinically, but lymphadenopathy is a more prominent feature in the prodrome and early stages of monkeypox illness. The prodrome period usually lasts one to three days before the rash develops. Like smallpox, lesions appear and evolve

through stages of macules, papules, vesicles, pustules, to crusts/scabs before falling off. Atypical presentations include initial signs of a genital or peri-anal rash prior to prodrome symptoms which may not spread to other parts of the body and having lesions at different stages of development.

Signs or Symptoms:

- Fever
- Chills and/or sweats
- Lymphadenopathy (swollen lymph nodes)
- Headache
- Myalgia (muscle/ body aches, back pain)
- Sore throat
- Cough
- Coryza
- Prostration or asthenia (profound weakness)

Suspect/Confirmed Case:

Monkeypox Suspect, probable or confirmed cases of monkeypox do not need to be reported immediately to the ministry. Reports shall comply with the timely entry of case requirements within one business day of the PHU receiving initial notification of the case/encounter/episode/incident as set out in iPHIS Bulletin "Timely entry of cases and outbreaks for diseases of public health significance" (2020, or as current).

World Health Organization states:

- Investigation of suspect cases should take place as soon as possible and include: clinical examination with appropriate personal protective equipment; exploring possible sources of infection; collecting and submitting specimens for laboratory analysis in a safe manner. For suspected, probable, and confirmed cases definitions, see WHO's Surveillance, case investigation and contact tracing for monkeypox, document.

A single case of monkeypox in a non-endemic area is considered an outbreak.

Given the atypical clinical presentation reported by cases during the current global monkeypox outbreak, WHO recommends that health care providers, particularly in affected communities,

should be aware of the signs and risk factors associated with monkeypox, and that any individual meeting the suspect case definition for monkeypox should be offered testing.

Declaring an outbreak in a long-term care home:
• Suspect outbreak: a single probable case of monkeypox acquired in the home/setting
• Confirmed outbreak: a single confirmed case of monkeypox acquired in the home/setting

Declaring an outbreak over:
An outbreak may be declared over by the public health unit (PHU) when there are no new cases in residents or staff linked to exposures in the setting after 42 days (two incubation periods) have passed from the last date that others were potentially exposed to an infectious case.

Room Placement of Case:
• Inpatient setting, place an individual with suspect, probable or confirmed monkeypox infection in a single-patient room with the door closed with a dedicated toileting facility or commode.
• If a single-patient room is not available, then precautions should be taken to minimize exposure to surrounding individuals, such as having the patient don a medical mask over their nose and mouth (as tolerated), maximizing distancing from others (i.e., seated away from others) and covering exposed skin lesions with clothing, sheet or gown as best as possible.

Close Contacts:
21-day monitoring period for close contacts of confirmed cases.

As soon as a suspect case is identified, contact identification and contact tracing should be initiated. Contacts should be notified within 24 hours of identification.

Active monitoring by public health of all contacts is done and public health is responsible for checking at least once a day to see if a person under monitoring has self-reported signs/symptoms.

• Any patient who has had a high, intermediate, or low risk exposure should monitor for signs and symptoms of MPX for 21 days after last date of exposure.

o Staff should monitor residents who are unable to self-monitor for signs and symptoms of MPX at least twice a day or once per shift including temperature checks and skin assessment.

• PHUs may use their discretion in deciding that a high-risk contact resident who was scheduled to be discharged/transferred from hospital should remain in hospital during their self-monitoring period.

o In particular, a PHU should assess the ability of both the resident contact (e.g. resident with dementia) and the setting for which the resident is being discharged/transferred to (e.g. staff capacity to complete an assessment for a new rash) to appropriately monitor for signs and symptoms MPX infection.

• Asymptomatic residents who are contacts of a confirmed case of MPX in a health care setting do not routinely need to be placed in additional precautions including if they are transferred to another unit within the hospital or to a different setting (e.g. transferred from hospital to a long-term care facility).

• Resident contacts who are considering donation of bodily fluids (e.g. blood, semen, breast milk) or HCT/Ps should first discuss this with a health care provider

• Should resident contacts develop any MPX signs or symptoms, including prodromal symptoms, the contact should be immediately placed in a single patient room with the door closed and a dedicated toileting facility or commode (to facilitate clinical assessment and consideration of appropriate testing).

Table 4: Risk of exposure assessment for a patient who is a contact of a health care worker MPX case in a health care setting ǂ

Risk of exposure	Description	Examples
High	Unprotected direct contact between a HCW case's skin lesion(s)/scab(s) (i.e., no gloves or gown) and a patient's unprotected skin	Patient had direct contact with HCW case's unprotected skin lesions (e.g., HCW had lesion on their hand and was not wearing gloves when in direct contact with patient or HCW had an uncovered lesion on their arm and they were not wearing a gown when the lesion came in direct contact with patient).
Intermediate	Does not meet high risk criteria, but interaction may result in an unprotected exposure to infectious materials such as: • Patient had non-transient close (within 2 metres) face-to-face contact with an unmasked HCW case (i.e., HCW was not wearing an N95 respirator or medical mask)	HCW case's lesions were covered, but HCW case was not wearing a medical mask and was in the patient care area where they had non-transient close (within 2 metres) face-to-face contact with an unmasked patient
Low	Does not meet high or intermediate risk criteria, but a limited exposure may have occurred without appropriate PPE for the situation	HCW case was doing vitals without wearing gown or gloves, where only contact was with patient's intact skin and the HCW case's lesions were covered and were not located on exposed areas such as their hands, arms, or face (i.e., HCW case only had covered genital or truncal lesions and no other signs or symptoms of MPX illness).
No/very low	An exposure deemed not meeting criteria for other risk categories	HCW case was wearing all PPE (i.e., eye protection, N95 respirator or medical mask, gown, and gloves) during all visits in the patient contact's care area or room

ǂ At the discretion of the local PHU or hospital occupational health/IPAC, an exposure may be re-classified to a different risk level due to context-specific factors

Post-Exposure Prophylaxis

As monkeypox is related to the virus causing smallpox, vaccines designed for smallpox will provide a degree of cross-protection. Previous data from Africa suggests that previous vaccines against smallpox may be up to 85% effective in preventing monkeypox infection.

Imvamune® (Bavarian Nordic A/S) vaccine is a third-generation smallpox vaccine authorized in Canada for adults 18 years and older for prevention of monkeypox infection.

NACI recommends that Imvamune vaccine be offered as pre-exposure prophylaxis to individuals at high risk of occupational exposure to orthopox viruses (including vaccinia and monkeypox) in a laboratory setting. The vaccine is recommended to be administered in two doses, 28 days apart, with a booster dose offered after 2 years if the risk of exposure is ongoing.

Antivirals will be offered to residents at the discretion of the ordering physician.

Hand Hygiene:
As per Four Moments of Hand Hygiene.
See policy: 2.3 – Hand hygiene

PPE:
See Policy – 2.2 – Personal Protective Equipment for the Healthcare Provider
- Gloves, Gown, Eye protection (e.g., face shields, safety glasses or goggles), Fit-tested and seal checked N-95 respirator (or equivalent); perform seal check after donning N95 respirator.

Duration:
- In health care settings, Additional Precautions are maintained until all scabs have fallen off and new skin is present.
- Individuals in self-isolation in the community, self-isolation is maintained until all scabs have fallen off and new skin is present AND they have been cleared by their PHU (no longer considered infectious).

Resident Transport:
Have the resident wear clean clothes/gown, wash their hands, wear a medical mask and cover their lesions to the best extent possible for transport.

Laundry:

- Care should be taken in the management of soiled laundry to avoid shaking or handling in a manner that may cause dispersal of microorganisms.

Point-of-care (i.e., within the patient environment):

- Follow Additional Precautions as indicated for entering the patient space. This includes wearing PPE (gloves, gown, fit-tested and seal-checked N95 respirator and eye protection) during collection and bagging of all linens.
- Do not sort or pre-rinse soiled laundry in care areas.

Waste disposal:

Containment and disposal of contaminated waste (e.g., dressings) in accordance with facility specific/public health guidelines for infectious waste.

Environmental cleaning and disinfection:

Contaminated surfaces and equipment contribute to the transmission of microorganisms and to the risk of health care-associated infection. Environmental contamination is increased when patients are coughing, sneezing, have large draining wounds, or extensive skin lesions. Effective environmental cleaning, disinfection and hand hygiene will interrupt direct patient to surface to patient or health care worker transmission.

Routine environmental cleaning and disinfection is adequate for monkeypox. This includes:

- ensure all horizontal surfaces that may be touched by the resident, and equipment that may have been used by or shared between residents are cleaned and disinfected after every use.

- Rooms cleaned and disinfected at least once daily, upon discharge and discontinuation of Additional Precautions. Additional cleaning as required.

- Shared showering facilities, including shower chairs, are to be cleaned after each use.

- Any surfaces/items that may come into contact with potentially infectious respiratory secretions, lesions or fluid from lesions (e.g. toilet seat, toilet handle) should be cleaned and disinfected after use and before use by another individual.

Use health care grade cleaning and disinfecting agents, with a Drug Identification Number (DIN) appropriate for cleaning and disinfection of environmental surfaces and shared equipment in the patient care environment. Follow the manufacturer's recommendations for use (e.g., dilution and contact time).

Activities that could re-suspend dried material from lesions (e.g., use of portable fans, shaking of linens, dry dusting, sweeping, or vacuuming) should be avoided. Wet cleaning methods are preferred.

Dietary:

Dishware and eating utensils are effectively decontaminated in commercial dishwashers with hot water and detergent. Reusable dishware and utensils may be used; disposable dishes are not required, managed as routine practices.

Care of the deceased:

- Prepare the body for transfer to the morgue or funeral as per routine organizational polices (e.g., cleaning, containing body fluids, placing in a body bag).
- Follow the same Additional Precautions used while the person was alive.
- Care is to be taken to avoid contaminating the exterior of the body bag

Resources:
Multi-Jurisdictional Monkeypox Outbreak 2022 – What We Know So Far; PHO

Infection Prevention and Control (IPAC) Recommendations for Monkeypox in Health Care Settings; June 2022

Recommendations for the management of cases and contacts of monkeypox (MPX) in Ontario; MOH; November 2022