

Official websites use .gov A .gov website belongs to an official government organization in the United States. Secure .gov websites use HTTPS A lock () or https:// means you've safely connected to the .gov website. Share sensitive information only on official, secure websites. These recommendations are intended for healthcare settings. Non-healthcare settings such as correctional facilities and homeless shelters should continue to follow CDC's Preventing Mpox Spread in Congregate Settings. On 4/5/2024: Infection prevention and control recommendations for healthcare settings are provided in the Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007). Recommendations and practices described in this 2007 guideline are intended to be used when providing care for any patient in a healthcare setting, including those with mpox infection. Additional supporting infection prevention and control information is provided below. Guidance addressing isolation for people with mpox infection outside of healthcare settings is available at Isolation and Infection Control at Home. In addition to Standard Precautions, if a patient seeking care is suspected to have mpox infection, additional infection control precautions (as described below) should be implemented. Infection prevention and control personnel should be notified immediately. Activities that could resuspend dried material from lesions (e.g., use of portable fans, dry dusting, sweeping, vacuuming) should be avoided. A patient with suspected or confirmed mpox infection should be placed in a single-person room; special air handling is not required. The door should be kept closed (if safe to do so). The patient should have a dedicated bathroom. Transport and movement of the patient outside of the room should be limited to medically essential purposes. If the patient is transported outside of their room, they should use well-fitting source control (e.g., medical mask) and have any exposed skin lesions covered with a sheet or gown. Intubation, extubation, and any procedures likely to spread oral secretions should be performed in an airborne infection isolation room. PPE used by healthcare personnel who enter the patient's room should include: Waste management (i.e., handling,

storage, treatment, and disposal of soiled PPE, patient dressings, etc.) should be performed in accordance with U.S. Department of Transportation (DOT) Hazardous Materials Regulations (HMR; 49 CFR parts 171-180.) Updated U.S. guidance for diagnostic samples and clinical waste advises that waste contaminated with Clade I or Clade II of mpox is designated as Category B infectious substances except when they contain or are contaminated with laboratory cultures of Clade I mpox virus. Refer to the current DOT Safety Advisory Notice for details. Facilities should also comply with state and local regulations for handling, storage, treatment, and disposal of waste, including Regulated Medical Waste. Standard cleaning and disinfection procedures should be performed using an EPA-registered hospital-grade disinfectant with an emerging viral pathogen claim. Products with Emerging Viral Pathogens claims may be found on EPA's List Q. Follow the manufacturer's directions for concentration, contact time, and care and handling. Soiled laundry (e.g., bedding, towels, personal clothing) should be handled in accordance with recommended [2.47 MB, 241 pages] standard practices, avoiding contact with lesion material that may be present on the laundry. Soiled laundry should be gently and promptly contained in an appropriate laundry bag and never be shaken or handled in manner that may disperse infectious material. Activities such as dry dusting, sweeping, or vacuuming should be avoided. Wet cleaning methods are preferred. Management of food service items should also be performed in accordance with routine procedures. Detailed information on environmental infection control in healthcare settings can be found in CDC's Guidelines for Environmental Infection Control in Health-Care Facilities and Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings [section IV.F. Care of the environment]. For patients with suspected or confirmed mpox infection in a healthcare setting: Decisions regarding discontinuation of isolation precautions in a healthcare facility may need to be made in consultation with the local or state health department, depending on the jurisdiction. In general, patients in healthcare facilities

who have had an mpox virus exposure and are asymptomatic do not need to be isolated, but they should be monitored. Monitoring should include assessing the patient for signs and symptoms of mpox, including a thorough skin exam, at least daily, for 21 days after their last exposure. Postexposure risk assessment and management for patients should be adapted from community guidance or healthcare guidance, depending on the nature and location of a patient's exposure. During the 21-day monitoring period: Be placed on empiric isolation precautions for mpox until (1) the rash is evaluated, (2) testing is performed, if indicated, and (3) the results of testing are available and are negative. Some patients may be unable to communicate onset of symptoms (e.g. a newborn, patients with delirium). Decisions on whether to isolate exposed patients who are unable to communicate about onset of symptoms should be informed by the risk of their exposure incident (how likely they are to develop mpox infection), risk that transmission would pose to other patients on their unit (e.g., immunocompromised patients), and other factors. To date, there have been no confirmed reports of mpox virus transmission from medical products of human origin (MPHO) including blood transfusion, organ transplantation, or implantation, transplantation, infusion, or transfer of human cells, tissues, or cellular or tissue-based products (HCT/Ps). As a precaution, people who have a high- or intermediate-risk exposure (Monitoring and Risk Assessment for Persons Exposed in the Community | Mpox | Poxvirus | CDC) should not donate blood, cells, tissue, breast milk, or semen while they are being monitored for symptoms. Given the morbidity and mortality among individuals awaiting organ transplantation, potential deceased donors who have been exposed and have no evidence of mpox virus infection, based on a physical examination, could be considered for organ donation following appropriate risk-benefit considerations. Potential living donors who have been exposed to mpox could consider deferring donation until 21 days following their last exposure. The risk of such wait time should be weighed against the morbidity and mortality risk for individuals awaiting

organ transplantation. All decisions should be based on appropriate risk-benefit considerations, recognizing that mpox virus has been detected in some samples taken from people who reported no symptoms. CDC will continue to monitor case data and available science for new or changing information about transmission. Additional information on safety considerations for blood and plasma donation is available at FDA's Information for Blood Establishments Regarding the Mpox Virus and Blood Donation and from the Association for the Advancement of Blood & Biotherapies (AABB) [251 KB, 9 pages]. The Organ Procurement and Transplantation Network (OPTN) Disease Transmission Advisory Committee is evaluating the implications for organ transplantation: OPTN/HRSA's Mpox and Solid Organ Donation For further questions please contact CDC: eocreport@cdc.gov Visitors to patients with mpox infection should be limited to those essential for the patient's care and wellbeing (e.g., parents of a child, spouse). Decisions about who might visit, including whether the visitor stays or sleeps in the room with the patient, typically take into consideration the patient's age, the patient's ability to advocate for themselves, ability of the visitor to adhere to infection prevention and control recommendations, whether the visitor already had higher risk exposure to the patient, and other aspects. In general, visitors with contagious diseases should not be visiting patients in healthcare settings to minimize the risk of transmission to others. Each risk level category in the table below is intended to highlight the need for monitoring and assist with determining the need for postexposure prophylaxis (PEP). The exposure risk level of any incident may be recategorized to another risk level at the discretion of occupational health services or public health authorities due to the unique circumstances of each exposure incident. Correct and consistent use of PPE when caring for a patient with mpox infection is highly protective and prevents transmission to HCP. However, unrecognized errors during the use of PPE (e.g., self-contaminating when removing contaminated PPE) may create opportunities for transmission to HCP. Therefore, in the absence of an exposure

described below, HCP who enter a contaminated patient room or care area while wearing recommended PPE, should be aware of the signs and symptoms of mpox; if any signs or symptoms of mpox occur, HCP should notify occupational health services for further evaluation and should not report to work (or should leave work, if signs or symptoms develop while at work). ¶ ACAM2000 and JYNNEOS are available for PEP. ¶¶

Factors that may increase the risk of mpox transmission include (but are not limited to): the person with mpox infection had clothes that were soiled with bodily fluids or secretions (e.g., discharge, skin flakes on clothes) or was coughing while not wearing a mask or respirator, or the exposed individual is not previously vaccinated against smallpox or mpox. People who may be at increased risk for severe disease include (but are not limited to): young children (e.g., children <1 year of age), individuals who are pregnant or immunocompromised, and individuals with a history of atopic dermatitis or eczema. Decisions on how to monitor exposed HCP are at the discretion of the occupational health program and public health authorities. In general, the type of monitoring employed often reflects the risk for transmission with more active-monitoring approaches used for higher risk exposures. Self-monitoring approaches are usually sufficient for exposures that carry a lesser risk for transmission. Even higher risk exposures may be appropriate for a self-monitoring strategy if occupational health services or public health authorities determine that it is appropriate. Ultimately, the person's exposure risk level, their reliability in reporting symptoms that might develop, the number of persons needing monitoring, time since exposure, receipt of PEP, and available resources, are all factors when determining the type of monitoring to be used. Asymptomatic HCP with exposures to mpox virus do not need to be excluded from work, but should be monitored (e.g., at least a daily assessment conducted by the exposed HCP for signs and symptoms of mpox infection) for 21 days after their last exposure. If symptoms develop, HCP should be managed as described below. If pox infection is ruled out, they may still have work restrictions

recommended if their diagnosis is one where restriction from work is recommended (e.g., varicella). During the 21-day monitoring period: As a precaution, HCP with exposures categorized higher than 'No risk' in the above table should not donate blood, cells, tissue, breast milk, or semen while they are being monitored for symptoms. Given the morbidity and mortality among individuals awaiting organ transplantation, HCP who have been exposed, but who are asymptomatic and without evidence of mpox virus infection, could be considered for organ donation following appropriate risk-benefit considerations. HCP with confirmed mpox infection should be excluded from work until all lesions have crusted, those crusts have separated, and a fresh layer of healthy skin has formed underneath. Ultimately, the decision on when to return to work will be made with their occupational health program, and potentially with input from public health authorities.

Healthcare personnel (HCP) refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. These HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Healthcare settings refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long-term acute-care facilities, inpatient rehabilitation facilities, nursing homes, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, dental offices, and others. Active monitoring typically

involves in-person visits, regular communications (e.g., phone calls, video conferences) between occupational health services, public health representatives, and the person being monitored. Self-monitoring typically involves persons self-reporting symptoms to occupational health programs or health departments if symptoms appear. On 10/31/2022: Information about human-to-human transmission of mpox virus is described in [How it Spreads | Mpox | Poxvirus | CDC](#). Transmission in healthcare settings has been rarely described. On 8/11/2022: On 7/01/2022:

