DEFENCE MEDICAL SERVICES (DMS) INFECTION PREVENTION AND CONTROL (IPC) POLICY

Introduction

1. There is a statutory requirement under The Health and Social Care Act 2008 (HSCA 2008 – Updated July 2015) for civilian healthcare providers to be registered with, and regulated by, the Care Quality Commission (CQC). Annex A outlines criteria of the HSCA 2008 Code of practice specific to IPC. The DMS is exempt from registration; however, it is MOD policy to apply UK standards where reasonably practicable[1, 2] irrespective of location. Therefore Regulations 12 (2) (h), 15 (2), and 21(b) of the HSCA 2008 are considered applicable to all DMS units including those within the Devolved Administrations and those based outside the UK.

Aim

2. The aim of this policy is to describe the IPC arrangements within the DMS, to detail responsibilities and to outline governance arrangements.

Scope

3. This policy provides a strategic framework for IPC in order for Service Commands (SC) to develop the necessary IPC infrastructure for their units, including Firm Base (FB) and deployed locations.

4. Healthcare services commissioned from external providers are subject to CQC scrutiny through the host's registration and are therefore out with the remit of this policy. However, units should assure themselves that services they commission meet required standards.

Definitions

5. The following definitions will be used throughout this policy:

a. **Service Commands (SC).** For the purpose of this leaflet, SC incorporates medical delivery elements within Navy Command HQ (NCHQ), HQ Army, HQ Air and Joint Forces Command including Permanent Joint Headquarters (PJHQ), Directorate of Special Forces (DSF) and Directorate of Healthcare Delivery and Training (Dir HDT).

b. **Medical Treatment Facility (MTF).** Any location, including vehicles and airframes, in which medical care is delivered.

c. **Medical Personnel.** All personnel engaged in delivering, supporting or managing medical care provision[3].

IPC Roles and Responsibilities in the DMS

6. IPC is concerned with the mitigation of avoidable risks of infection and the control and management of unavoidable risks to patients, medical personnel and visitors within medical treatment facilities. IPC in the DMS is underpinned by a considerable body of legislation and guidance, examples are given at Annex B.

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[1] Secretary of State's Policy Statement on Safety, Health, Environmental Protection and Sustainable Development (2010)
[2] JSP 950 Leaflet 1-4-1 The Operational Patient Care Pathway.
[3] Includes Exercise Rehabilitation Instructors, Logistics personnel working in mortuary or handing healthcare/infectious waste, Service Police handling bodies or blood stained Personal Protective Equipment (PPE) (body armour) and Defence Fire Service assisting with casualty evacuation.

7. Defence IPC is a multi-layered capability which provides a range of services across all levels of Command. SC are to ensure individuals meet their obligations with regard to IPC standards.

a. **HQ SG.** Responsible for publication of IPC policy. IPC policy is to be endorsed by the Medical Policy Steering Group and reviewed at least every 5 years to ensure continual improvement.

b. **SG Medical Directorate.** Responsible for the development and maintenance of clinical policy and provision of Defence subject matter expert (SME) advice. Provides direction on Defence level clinical policy to inform SC on clinical and technical matters and issues related to delivery and training. Supports deployed Medical Force Elements (Med FE) and Joint Task Force Headquarters (JTFHQ) with strategic and operational SME advice.

c. **Dir HDT.** Responsible for healthcare delivery and the provision of accredited training at different levels tailored towards national guidance incorporated in MOD policy with input from IPC SME.

d. **Service Commands.** Preparation of Force Elements at Readiness and support to Med Force Elements (FE) on Ops/Ex under SC OPCOM with SME advice and reach back. SC are to maintain a network of trained IPC Link Personnel. Defence Primary Health Care (DPHC) (Dental) and Director, Army Veterinary and Remount Services (DAVRS) are to have an IPC Lead for their specialties who links to the SC IPC SME.

e. **Operations.** The deployed IPC SME provides tactical SME advice to the deployed Medical CoC, and supports Med FE in the management of patients from point of injury/illness through to deployed hospital care (DHC), including medical evacuation. The deployed IPC SME will most likely be based at a DHC capability to allow for wider tactical awareness but has a theatre wide remit.

f. **Unit level/MTF.** Where there is no qualified IPC practitioner, commanders are to identify an IPC Link Person for their MTF who will be responsible for co-ordinating IPC activity and the dissemination/delivery of reach back[4] information/advice.

g. **Additional IPC personnel.** At every level of the organisation there are personnel with specific IPC responsibilities, these are outlined at Annex C.

Governance and Assurance

8. This leaflet covers broad governance and assurance processes in relation to IPC, and must be read in conjunction with JSP 950 Leaflet 5-1-4 Healthcare Governance and Assurance in the DMS and PJHQ J4 Medical Handbook for Joint Operations.

a. **Governance**

(1) **Risk Management.** All personnel responsible for the delivery of medical care are to ensure that the appropriate assessment of IPC risks to patients, medical personnel and visitors to MTFs has been undertaken and that risks identified have been appropriately managed, recorded and reported in accordance with JSP 892 Risk Management.

(2) **Audit.** Audit and service evaluation are essential parts of the quality improvement agenda. Compliance with IPC Standard Operating Procedures (SOPs) must be evaluated at least annually or more frequently, based on risk. SC must ensure

[4] See serial 8.a.(4)

that MTFs can provide evidence of an IPC audit programme as part of their assurance portfolio. Results are to be submitted, via the MTF's governance chain, to the SC IPC SME.

(3) **Standard Operating Procedures (SOPs).** It is recognised that FB and operational FE have differing IPC challenges and are therefore to have SOPs in place that meet their individual requirements. Annex D recommends that SOPs should be considered based on clinical capability. Where there is a requirement to develop SOPs at unit level this is to be done in accordance with extant SC IPC policies and ratified by the SC IPC SME.

(4) **Access to SME advice.** SC are to ensure that DMS MTFs have timely access to IPC and microbiology SME advice. Appropriate arrangements for access to IPC or microbiology reach back are to be set out in local SOPs. Advice can be sought via the Medical Directorate SG-DMed-MedD-ClinGpMailbox@mod.uk. The request for information will then be forwarded to the appropriate Defence Consultant Advisor/Defence Specialist Advisor. Urgent advice can be sought from:

(a) **Microbiology.** +44 7771 945 481

(b) **IPC.** +44 7767 675 661

(c) **Public Health.** +44 7899 067381

(5) **Force Generation.** Force generation authorities are to ensure appropriate and timely IPC SME input to pre-deployment training, validation and assurance activities.

b. **Assurance**

(1) **DMS Common Assurance Framework (CAF).** MTFs must be assured against the HSCA 2008 standards. These have been incorporated into the DMS CAF. Where an alternative, IG approved assurance tool is utilised, the standards of the HSCA 2008 are to be incorporated.

(2) **Significant Events (SE).** SC are to ensure that systems are in place which enable timely IPC SME input to SE reports (SER) and root cause analysis.

Reports and Returns

9. Microbiological data from operations and Role 4, including Defence Medical Rehabilitation Centre (DMRC) will be collated. This is added to the Wound Infection Surveillance Programme (WISP). The data is utilised for research and information exploitation. Positive microbiological results are to be collated, redacted and emailed to SG-DMed-MedD-ClinGpMailbox@mod.uk[5].

a. **Operations.** Where there is access to laboratory services[6] microbiological wound results and requested additional results are to be collated weekly in order that timely clinical evaluation, feedback and SME guidance can be provided. The data required may vary depending on the operation and MEDINT but should include Lab No, micro-organism/s identified, type and site of sample, antibiogram, relevant clinical data e.g. UK Forces/Local National, mechanism of injury/disease, surgical interventions/invasive devices.

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[5] This provides clinical oversight by a Consultant Microbiologist and IPC SME inorder to provide timely advice and guidance as well as informing SOP and policy development. The frequency of data collection may vary dependant on the operation and number of cases seen and will be dependent on J6 capability.

[6] it is recognised that not all operations will have a laboratory capability.

b. **WISP.** The UK Wound Infection Surveillance Programme (WISP) is a surveillance tool set up to monitor and record the incidence of wound infection in UK Service personnel returning from operations, in order to capture data on wound infection and provide a clinical base of evidence with which to inform future practice and policy. The main objectives are to ascertain the numbers of wound infections in military patients through prospective and active surveillance, to identify the micro-organisms causing wound infections in military patients through prospective and active surveillance and to identify key risk factors that influence wound infections occurring in military patients. Wound infection data can be requested, via the Medical Directorate at SG-DMed-MedD-ClinGpMailbox@mod.uk.

c. **DMRC.** Microbiology results for cases resulting from operational activity are to be collated, in conjunction with the wound surveillance co-ordinator, as part of the WISP.

Education and Training

10. a. **IPC Specialist Practitioners.** The minimum base level qualification for an IPC practitioner is 60 credits at degree level on an accredited IPC course with specified modules and accompanying practice placement overseen by a military mentor.

b. **Annual IPC Training.** All Medical Personnel engaged in patient care delivery (either directly or as part of a delivery organisation) are to undertake demonstrable IPC training annually[7]. SC are responsible for ensuring auditable compliance records are maintained which are to be reviewed as part of their assurance portfolio. Deploying units are to ensure individual reinforcements provide evidence of pre-deployment IPC training. As a minimum the DLE IPC e learning (via the Defence Gateway) should be completed. For registered nurses, such training should facilitate compliance with the DONC Core Competency 22 IPC.

c. **IPC Link Practitioners (IPCLP). Personnel identified as IPC link practitioners are to undertake approved training.** This training can be sourced from external providers[8].

d. **Non-DMS Personnel.** Non-DMS personnel working in a healthcare environment or in support of healthcare[9] are to complete the DLE IPC course (via the Defence Gateway) at the start of their commitment and annually for the duration of their commitment. Commanders are to ensure auditable records of training are maintained.

Links to other Defence IPC policies and SOPs

11. Current SC IPC policies[10] can be located via the Medical Directorate IPC MOSS page.

Annexes:

A. Criteria of the HSCA 2008 code of practice.
B. Examples of legislation and guidance relevant to IPC.
C. Roles and responsibilities of IPC personnel.
D. IPC policies appropriate to clinical capability.

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[7] This can be in the form of the DPHC Non-Clinical Staff IPC powerpoint presentation, the DLE IPC course, host Trust mandatory training or taught session by an appropriately qualified individual eg an IPC SME or an appropriately supervised IPC Link Practitioner.
[8] DHET TNA and review in progress: Consult: SG-DMed-MedD-ClinPolIPCSO2@mod.uk
[9] For example Exercise Rehabilitation Instructors, Royal Logistic Corps, Service Police, Defence Fire Service.
[10] RN IPC Policy Br1991 Ch13
DGPL 02/13 IPC for healthcare in the LAND environment
TMW IPC SOP
DPHC (Dental) SOP: Ch 13 IPC
PJHQ IPC SOPs

CRITERIA OF THE HSCA 2008 CODE OF PRACTICE

These criteria have been integrated into the DMS CAF. Further details and guidance for compliance is available from Health and Social care Act 2008: Code of Practice for the prevention and control of infections.

Criterion	What needs to be demonstrated?
1	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that the care environment and other users may pose to them.
2	Provision and maintenance of a clean and appropriate environment, in managed premises, that facilitate the prevention and control of infections.
3	Appropriate antimicrobial use to optimise patient outcomes, to reduce the risk of adverse events, and antimicrobial resistance.
4	Suitable, accurate information on infections to service users, their visitors, and any person/organisation (civilian or military) concerned with providing further support or care in a timely fashion. This includes evidence based, validated, patient information leaflets.
5	Systems to ensure prompt identification of people who have, or are at risk of developing an infection, so that they receive timely and appropriate interventions to reduce the risk of transmission to/from others.
6	Systems to ensure that all medical personnel are aware of, and discharge their responsibilities in the process of preventing and controlling infection.
7	Provision of, or timely access to, suitable isolation facilities; based on medical intelligence and risk assessment.
8	Access to suitable laboratory support; based on medical intelligence and risk assessment..
9	Standard Operating Procedures, SC and Strategic policies, to help prevent and control infection, are in place, accessible and adhered to.
10	Systems are in place to meet occupational health obligations and the needs of medical personnel, in relation to infection[11].

[11] See JSP 950 Volumes 6 and 7

EXAMPLES OF LEGISLATION AND GUIDANCE RELEVANT TO IPC

It is to be noted that this list is not exhaustive but contains the main legislation and guidance that influence the IPC agenda.

Ser	Subject	Title
1	**General**	Health and Social Care Act 2008[12] [13] EPIC 3 (2014) National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England NICE clinical guideline 139 (2012) Prevention and control of healthcare-associated infections in primary and community care NICE clinical guidelines CG74 (2008) Surgical site infections: prevention and treatment
2	**Health and Safety**	Health and Safety at Work Act 1974 The Control of Substances Hazardous to Health Regulations 2002 European Council Directive 2010/32/EU (the Sharps Directive).
3	**Department of Health**	DoH (2008) Health and Social care Act 2008: Code of Practice for the prevention and control of infections and related guidance (Updated 2015). DoH (2010) Essence of Care; Benchmarks
4	**Waste**	The Hazardous Waste (England and Wales) Regulations 2005. SI no 2005/894. DoH (2013) Environment and sustainability: Health Technical Memorandum (HTM) 07-01: Safe Management of Healthcare Waste. DoH (2007) HTM 07-06: Disposal of pharmaceutical waste in community pharmacies.
5	**Environmental cleanliness**	National Patient Safety Agency (2007) The National Specifications for cleanliness in the NHS: A framework for setting and measuring performance outcomes. National Patient Safety Agency (2009) The Revised Healthcare Cleaning Manual. Health and Social Care Information Centre (2014) Patient-led assessments of the Care Environment (PLACE)
6	**Sterile instruments**	DoH (2013) HTM 01-05: Decontamination in primary care dental practices DoH (2013) Choice Framework for local Policy and Procedures (CFPP) 01-01 –management and decontamination of surgical instruments (medical devices) used in acute care. Parts A-E.
7	**Linen**	DoH (2013) CFPP 01-04 – Decontamination of linen for Health and Social Care.
8	**Hand Hygiene**	World Health Organization (2006) Guidelines on Hand Hygiene in Health Care. European Committee for Standardisation (CEN) standard (EN1500); Chemical disinfectants and antiseptics - hygienic hand rub.
9	**Built Environment**	Health Building Notes (HBN) in particular; HBN 00-09: Infection control in the built environment (2013).
10	**Antimicrobial Resistance**	DoH (2013) UK five year Antimicrobial Resistance Strategy 2013-2018 World Health Organization (2015) Global action plan on Antimicrobial Resistance
11	**Sharps**	NHS Employers 2015 Managing the risks of sharps injuries HSE Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 Guidance for employers and employees

[12] Regulation 12 (2) (h): "assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated."
[13] Regulation 15 (2) "The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used."

ROLES AND RESPONSIBILITIES IPC AND RELATED PERSONNEL[14, 15]

1. **Medical Director (Med Dir).** Retains overall accountability for ensuring that the DMS meets its statutory and non-statutory obligations in respect of maintaining patient safety and appropriate standards of clinical care in relation to IPC.

2. **Director of Infection Prevention and Control (DIPC)[16].** DIPC is accountable to the Med Dir. They are responsible for providing oversight, assurance, strategic direction and leadership whilst ensuring IPC is represented at the highest level.

3. **SO2 Clinical Policy IPC.** Responsible for the development and promulgation of strategy, joint policy, annual programme, annual report and strategic performance indicators. Deputy DIPC to SG. SME to the Med Dir, PJHQ[17] and DSF. Manages the governance and assurance framework for IPC across the DMS on behalf of the DIPC, including DMS corporate level trend analysis of IPC related SER. Provides co-ordination of SME advice and guidance on IPC aspects of new and emerging equipment capabilities. Chairs the IPC working Group (IPCWG).

4. **SC SMEs.** Autonomous specialist practitioners who advise both Comd on risks within their organisation and clinicians on patient risk and management. Provide IPC leadership across their AoR to ensure IPC is embedded within the organisation. Support Force Generation including training implementation and IPCLP preparation, and provide FB and Role 1-3 IPC validation and assurance. Assist in the formulation, implementation and monitoring of SC strategy and policy. Provide analysis and feed back for IPC related SER, service evaluation reports and reach back requests for information. Ensure the provision of SME advice and guidance on IPC aspects of new and emerging equipment capabilities. Provide development and support to a network of IPCLP. Provide IPC reach back for operations in liaison with DIPC. DPHC (Dental) and DAVRS are to have an appropriately qualified lead for their specialties.

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[14] 20120423-RAFMS IPC Strategy 2012-2014 final-U.
[15] DOCTRINE NOTE 08/02. Army IPC - employment of assets in support of LAND component operations.
[16] DoH (undated). Director of Infection Prevention and Control Role Profile.
[17] This excludes Fleet assets active under the authority of PJHQ, which remain the responsibility of NCHQ IPC SME who feeds back to DIPC via SO2 Clin Pol IPC.

Ser		Provider	Contact[18]	AoR
1	Med Dir	SO2 Clin Pol IPC, Med D	SG-DMED-MEDD-ClinPolGpMailbox@mod.uk 01214158878	PJHQ, DSF
2	NCHQ	IPC SME, Med Div	Navymed-ipcnurse@mod.uk 93832 5585 02392 625585	R1 (RAP), R2 LM (CFSG and MRS), Role1-3 Afloat.
3	HQ Army	SO2 IPC, AMD	Armymed-health-ipc-so2@mod.uk 942612933 01276412933	Role1-3 including AMMG, DAVRS
4	HQ Air	SO3 IPC, TMW	AIR38Gp-TMWIPCFlt@mod.uk 95461 4203 01993 842551 ext 4203	Tac & Strat Aeromed, CCAST, ASU, ATI, Role1, Role2(Air)
5	HQ DPHC	***TBC.*** IPC advice is available through SC SLA, via HQ DPHC (as an interim measure)		DPHC including DPHC(Dental)[19] and Rehab

5. **Microbiology reach back.** The reach back system provides MTFs with access to expert advice from a Consultant Microbiologist. DCA CDC or Defence Consultant Microbiologist can be contacted on +44 7771 945 481 or, for non-urgent enquiries, via the Medical Directorate: SG-DMedD-MedD-ClinGpMailbox@mod.uk.

6. **DSA IPC.** Responsible for the provision of SME advice and strategic management of the IPC cadre within Defence. The role of the DSA is covered by JSP 950 Leaflet 10-3-2 The Role of Defence Consultant Advisors and Defence Professors.

7. **SC Specialist Nurse Advisors (SNAs) IPC.** Usually the SC SME. Work with the SC to advance military nursing in their specialty. Responsible for operational management of their specialist cadres. Advise SC on IPC personnel, training and competence. Advise DIPC on SC issues and requirements. Advise DSA IPC on SC requirements. SG-DMed-MedD-DSAIPC@MOD.UK.

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[18] Please note e-mails and telephone numbers are subject to change.
[19] IPC leads for DPHC(Dental) are SO1 Clin Ops (Dental) and WO Clin Ops (Dental)

8. **Deployed IPC SME**[20]**.** Responsible for the provision of expert advice to the Med CoC and all clinical/tactical advice to deployed clinicians throughout the Med chain. Provision of specialist arms length advice to the pre-hospital care arena. Responsible for IPC governance of all MTFs within their AoR. Lead for infection related root cause analysis/post infection reviews.

9. **IPCLP**[21, 22, 23, 24]**.** SC are required to have a network of IPCLP to deliver Comd intent. All IPCLP[25] are to complete the IPCLP competency: DONC IPC Specialist level 2 or approved equivalent for non-nurses. Responsible for promoting good IPC practice at a tactical level. This includes promoting provision of a clean, appropriate environment and equipment. They are the lead for IPC quality improvement activity within their department/MTF. IPCLP require dedicated time to carry out this role, this should be negotiated locally based on the unit's risk assessment of their IPC requirements.

10. **IPCWG.** The IPCWG takes the form of a monthly teleconference (tc) and a meeting no less than twice yearly. Terms of reference for this WG are available from SG-DMed-MedD-ClinPolIPCSO2@mod.uk. The IPCWG provides the DIPC with oversight of IPC issues across the DMS and advises on IPC strategy and policy and training standards. It monitors IPC trends[26] and drives quality improvement. Provides clinical advice & professional support to IPC SMEs, and IPCLPs.

11. **IPC Research nurse.** Identify areas for potential research. Undertake and assist in the development of research**.** Assist the IPC cadre in publication. Present research findings as appropriate. Identify areas for policy and training development. SG-DMed-MedD-ClinResearchIPC@mod.uk

12. **Clinical Infection Surveillance Lead.** Co-ordination and management of end to end *clinical* infection data. Analyse and interpret data to identify areas for audit, research, policy and training. Present surveillance findings as appropriate.

13**.** **Healthcare personnel.** Attend mandatory and other training for IPC and ensure they are current. Responsible for accessing, understanding and adhering to IPC policy.

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[20] The Deployed IPC SME will usually be based at R2(E)/R3. This allows them oversight of ID and HAI issues across the Medical AOR.
[21] EU Council Recommendation 2009/C 151/01.
[22] Department of Health. Clean Safe Care Reducing infections and saving lives 2008.
[23] European Centre for Disease Prevention and Control. Core competencies for infection control.
and hospital hygiene professionals in the European Union. 2013
[24] The Role of the Link Nurse in IPC, RCN 2012.
[25] Including non-nursing personnel and those working within the Firm Base (FB).
[26] In conjunction with the Patient Safety and Quality Improvement Group (PSQIG), to identify IPC lessons emerging from assurance visits, SEs, audit and patient experience data.

14. **Antimicrobial Stewardship Lead.** Chair of the Antimicrobial Stewardship Committee. Develop, oversee implementation and monitor compliance with antimicrobial prescribing policy.

15. **DSA CSSD.** Responsible for developing and monitoring compliance with the invasive device decontamination policy in respect to reprocessing sterile or sterilised instruments. The role of the DSA is covered by JSP 950 Leaflet 10-3-2 The Role of Defence Consultant Advisors and Defence Professors.

16. **Decontamination Lead.** Responsible for developing and monitoring compliance with decontamination policy and cleanliness programme in respect to the environment, linen, non invasive equipment and medical devices (ie beds, commodes).

IPC POLICIES APPROPRIATE TO CLINICAL CAPABILITY

1. Guidance on SOP content is available from SC IPC SMEs and the Health and Social care Act 2008: Code of Practice for the prevention and control of infections.

2. IPC SOPs are to be easily accessible by all Med personnel and written in plain English. As a minimum SOPs are to include:

   a. Legal and statutory obligations.

   b. National guidance and best practice standards, where applicable.

   c. IPC management arrangements, lines of responsibility and accountability, and identify ownership of IPC at all levels.

   d. Arrangements for access to, and contact details of, microbiology and IPC reach back.

   e. Date of ratification and review, ownership[27], authorship and by whom the policy will be applied.

[27] ie who commissioned and retains managerial responsibility.

IPC POLICIES APPROPRIATE TO CLINICAL CAPABILITY

SOPS		MTF Roles								
		Role 1	Role 2 (LM)[28]	Role 2 (E) & Role 3	DMRC	MedEvac	CCAST	ATI	DPHC[29] excluding Dental	DPHC(Dental)
1	Standard precautions, includes: • Hand Hygiene • Personal protective equipment (medical) • Sharps stewardship[30] • Environmental decontamination, including use of disinfectants. • Management of reusable linen • Decontamination of reusable medical devices/equipment[31] • Safe handling and segregation of healthcare waste within the med chain[32]	✓	✓	✓	✓	✓	✓	✓	✓	✓
2	Aseptic technique	✓[33]	✓	✓	✓	✓	✓	✓	✓	✓
3	Outbreaks of communicable infection	✓	✓	✓	✓	N/A	N/A	✓	✓	✓
4	Isolation/segregation of service users with an infection	✓	✓	✓	✓	✓	✓	✓	✓[34]	N/A
5	Prevention of occupational exposure to blood borne viruses (BBVs) including prevention of	✓	✓	✓	✓	✓	✓	✓	✓	✓

[28] Role2 (LM) includes: LSG, AASG, CFSG, R2 Afloat, R2 Air.
[29] including MRS & RRUs
[30] Healthcare personnel are to have effective arrangements in place for the safe use and disposal of sharps, including safer sharps, where reasonably practicable to do so.
[31] including standards required prior to repair or disposal iaw JSP 950 leaflet 2-10-3. Defence Medical Services Medical Devices Decontamination Policy (MDDP)
[32] Final disposal may be covered in a different SOP i.e. J4
[33] Applicable to Pre-hospital emergency care in a permissive environment. N/A to care under fire /Tactical field care.
[34] RRUs should have an SOP covering exclusion of Pers with communicable infection.

SOPS		MTF Roles								
		Role 1	Role 2 (LM)[28]	Role 2 (E) & Role 3	DMRC	MedEvac	CCAST	ATI	DPHC[29] excluding Dental	DPHC(Dental)
	sharps injuries									
6	Risk assessment and management of occupational exposure to BBVs, including local arrangements for access to post exposure prophylaxis[35]	✓	✓	✓	✓	✓	✓	✓	✓	✓
7	Closure of premises/wards/rooms/ departments to admissions	N/A	✓	✓	✓	N/A	N/A	N/A	✓[36]	✓

[35] Should include immediate action drills, local arrangements for exposure reporting, exposure risk assessment and access to HBV and HIV PEP and follow-up iaw JSP 950 Lft 7-2-1Guidance on Risk Assessment and Immediate Management of Needle Stick / sharps/ blood/ body fluid and tissue exposure incidents.

[36] Applicable to MRS only.

8	Single use equipment	✓	✓	✓	✓	✓	✓	✓	✓	✓
9	Antimicrobial prescribing	✓	✓	✓	✓	N/A	N/A	N/A	✓[37]	✓
10	Notification of infections, both notifiable diseases and reporting HAI.	✓	✓	✓	✓	✓	✓	N/A	✓[38]	N/A
11	Control of outbreaks and infection with specific alert organisms	✓	✓	✓	✓	N/A	✓	N/A	✓[39]	N/A
12	Reprocessing of reusable instruments[40] including and management of devices with CJD/vCJD risk.	N/A	✓	✓	✓	N/A	N/A	N/A	✓[41]	✓
13	Packaging, handling and transport of laboratory specimens[42]	✓	✓	✓	✓	N/A	N/A	N/A	✓[43]	✓
14	Care of deceased persons with communicable infection	✓	✓	✓	N/A	✓	✓	✓	N/A	N/A
15	Use and care of invasive devices	✓	✓	✓	✓	✓	✓	✓	✓[44]	✓
16	Infection surveillance and data collection	✓	✓	✓	✓	N/A	N/A	N/A	✓[45]	N/A
17	Dissemination of information	✓	✓	✓	✓	✓	✓	✓	✓	✓
18	Isolation facilities	✓	✓	✓	✓	N/A	N/A	✓	✓[46]	N/A
19	Uniform and dress code[47]	✓	✓	✓	✓	✓	✓	✓	✓	✓
20	IPC requirements for rehabilitation gyms and aquatic therapy resources	N/A	N/A	✓	✓	N/A	N/A	N/A	RRUs only	N/A
21	IPC requirements of management of animals within a MTFfacility[48]	N/A	✓	✓	✓	N/A	N/A	N/A	N/A	N/A

[37] N/A to RRUs.
[38] N/A to RRUs.
[39] N/A to RRUs.
[40] Includes laryngoscopes held for resuscitation.
[41] N/A to RRUs.
[42] iaw JSP 800: Defence Movement and Transport Regulations
[43] N/A to RRUs.
[44] Applicable to MRS only.
[45] N/A to RRUs.
[46] N/A to RRUs.
[47] The 'Bare below the elbow' principle should be complied with when delivering clinical care. However, this is N/A where long sleeves are required for safety/ tactical/ operational purposes.
[48] Includes Military and Civilian Working Dogs (when working and as casualties), assistance dogs and Pets As Therapy animals