

**NATO STANDARD**

**AMedP-9.2**

**GUIDELINES FOR A MULTINATIONAL  
MEDICAL UNIT**

**Edition A Version 1**

**JANUARY 2018**



**NORTH ATLANTIC TREATY ORGANIZATION**

**ALLIED MEDICAL PUBLICATION**

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**NORTH ATLANTIC TREATY ORGANIZATION (NATO)**

**NATO STANDARDIZATION OFFICE (NSO)**

**NATO LETTER OF PROMULGATION**

15 January 2018

1. The enclosed Allied Medical Publication AMedP-9.2, Edition A, Version 1, GUIDELINES FOR A MULTINATIONAL MEDICAL UNIT, which has been approved by the nations in the Military Committee Medical Standardization Board, is promulgated herewith. The agreement of nations to use this publication is recorded in STANAG 2552.
2. AMedP-9.2, Edition A, Version 1, is effective upon receipt and supersedes AMedP-1.3, Edition A, Version 1, which shall be destroyed in accordance with the local procedure for the destruction of documents.
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4. This publication shall be handled in accordance with C-M (2002)60.



Edvardas MAŽEIKIS  
Major General, LTUAF  
Director, NATO Standardization Office

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## RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
FRA	<p>France is ready to implement STANAG 2552 as from its promulgation, but considers that some aspects of the allied publication AMedP-1.3, which are mentioned below, are too vague and will have to be better expanded and clarified when nations will engage in the negotiation of a memorandum of understanding.</p> <p>Indeed, it will be possible to integrate civilian components into a multinational medical unit (MMU); if this is the case, their degree of involvement, their responsibilities and their operating procedures must be explained. The use of civilian assets might lead, for instance, to a loss of traceability of the records of the injured who will be taken care of.</p> <p>AMedP-1.3 is also unclear from the budgetary point of view because it seems that nations that are providing equipment might in the end contribute financially twice bear the costs twice as a result of the cost-sharing arrangement.</p> <p>In addition, the management of medical reports is not defined for the civilian patients who would be treated within MMUs.</p> <p>France therefore reserves the right to better detail:</p> <ul style="list-style-type: none"> <li>- the limits placed on the use of civilian bodies;</li> <li>- the budget process;</li> <li>- the medical data flow and management process.</li> </ul>
HRV	<p>Templates proposals in the Annexes of this document will be used in the Croatian Armed Forces in accordance with national legislation and the obligations of the Republic of Croatia regarding the capability Targets.</p>
HUN	<p>HUN is ready to ratify and implement the STANAG with the following reservation. The ratification and implementation of the STANAG by HUN cannot be interpreted in a way stipulating that HUN approves or accepts the concept or contents of the MOU templates set out in the Annexes to the STANAG. HUN will not consider itself bound by the templates, neither as the exclusive starting point, nor as a whole or a part of a draft MOU. In case of the</p>



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<b>CHAPTER 1: GUIDELINES FOR A MULTINATIONAL MEDICAL UNIT (MMU)</b>
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**1.1. GENERAL**

1. Recent experiences have indicated that establishing a Multinational Medical Unit (MMU) can be a very complex operation. The information provided in this publication can expedite planning and establishment of an MMU, and establish a common understanding between participant nations. This information is intended to serve as templates and guides and will require some revision based on the operational theatre, participating nations, health services support required and health service support available in the host nation and neighboring countries.

**1.2. AIM**

2. The aim of this publication is to:

- a. Provide a template for Memorandum of Understanding relating to establishment of a MMU to allow for rapid implementation and standardization between participating nations;
- b. Provide a template for a Memorandum of Understanding to allow the Lead Nation to seek financial compensation via the NATO Common Funding process, as well as agreeing upon the Lean Nation responsibilities; and
- c. Provide planning considerations and sample unit standard operating procedures in the form of an Aide Mémoire in order to facilitate lean nation planning and preparation for the deployment of a MMU.

**1.3. MOU TEMPLATE FOR A MMU**

3. Annex A contains a sample template for an MOU relating to the establishment of a Multinational Medical Unit (MMU) to allow for rapid implementation and standardization between participating nations. When establishing an MMU, MOU templates will be used as a starting point to ensure standardization, and should be modified based on national legal, financial and operational necessities and requirements. No example has been provided for follow on Implementing Agreements (IA) to the MOU as the content of the IA will be determined based on the specific mission requirements.

**1.4. MOU FOR LEAD NATION RESPONSIBILITIES AND NATO COMMON FUNDING**

4. Annex B contains a template for an MOU to assist the Lead Nation in seeking financial compensation for NATO Common Funding costs associated with the MMU. The template will be used as a starting point to allow for rapid development of the MOU and

negotiation with SHAPE and should be modified based on national legal, financial and operational necessities and requirements. The template also establishes the financial and logistical responsibilities of the Lead Nation to ensure there is agreement between participating nations during the establishment phase of a MMU.

## **1.5. CONSIDERATIONS WHEN DEVELOPING A MULTINATIONAL MEDICAL UNIT**

5. Annex C contains an Aide-Memoire that has been developed to highlight issues which should be considered during the planning and establishment of an MMU. Though future NATO operational theatres and missions may differ, the Aide Memoire has been developed based on previous experiences / Lessons Learned and can provide a Lead Nation with a start point from which to manage the differing requirements and contributions of participating nations.

## **1.6 UNIT STANDARD OPERATING PROCEDURES**

6. Annex D offers a comprehensive example of what Unit Standard Operating Procedures can look like for a MMU in a theatre of operations. Annex D serves as a model only and needs to be refined and adapted to the specific environment in which the MMU is planning to evolve and operate.

**ANNEX A: SAMPLE MOU TEMPLATE FOR A MULTINATIONAL MEDICAL UNIT**

***MEMORANDUM OF UNDERSTANDING***  
***BETWEEN***  
***THE MINISTRY OF DEFENCE OF LEAD NATION***  
***AND***  
***THE MINISTRY OF DEFENCE OF TROOP CONTRIBUTING NATION A***  
***AND***  
***THE MINISTRY OF DEFENCE OF TROOP CONTRIBUTING NATION B***  
***REGARDING***  
***THE MULTINATIONAL PROVISION OF MEDICAL SUPPORT IN***  
***THE MULTINATIONAL MEDICAL UNIT***  
***TO BE LOCATED AT LOCATION***  
***IN SUPPORT OF THE NATO-LED***  
***FORCE***

## **INTRODUCTION**

The Ministry of Defence of *Lead Nation*, the Ministry of Defence of *TCN A* and the Ministry of Defence of *TCN B*, (hereafter jointly referred to as the Participants):

HAVING REGARD to their mutual desire to strengthen defence co-operation;

HAVING REGARD to their Armed Forces serving together as part of the NATO-led *Force* deployed to the country of *Location*. *Name of Force* is mandated under Chapter VII of the United Nations (UN) Charter by UN Security Resolutions *WXYZ*;

IN RECOGNITION of the fact that it is in the Participants' interest to pursue achievable efficiencies of scarce and expensive military medical resources and in particular avoidance of duplication of medical effort in the theatre of operations;

IN CONSIDERATION of the potential additional opportunities through a multilateral provision of medical support, in the field of medical doctrine and training, exchange of medical knowledge, exchange of consultants and other medical specialists; and

IN RECOGNITION that Lead Nation will act as lead nation for the purposes of coordination and procurement of all logistic supplies, support and services (LSSS) and equipment for the Role (state role level) Multinational Medical Unit;

ACKNOWLEDGING the extant agreements or arrangements between or among the Participants and the DESIRE to formalize arrangements whereby such multinational provision may be established;

HAVE REACHED the following understandings:

## **SECTION ONE – PURPOSE**

1.1 The purpose of this Memorandum of Understanding (MOU) is to set out the arrangements for the provision of multinational medical support in the *Lead Nation led* Multinational Medical Unit to be located at *Location*. Hereinafter this unit will be referred to as the MMU.

## **SECTION TWO – SCOPE**

2.1 This MOU outlines the definitions, command and control, jurisdiction, medical considerations, logistics and other support, finance, claims, security and other general principles concerning the responsibilities of Participants regarding the relevant procedures, sustainability and multinational manning of the MMU located at *Location*. It does not address the detailed arrangements for the organization, manning and equipping



of the MMU, which will be the subject of a subsequent Implementation Agreement (IA), which will be pursuant to this MOU.

### **SECTION THREE – DEFINITIONS**

3. For the purposes of this MOU the following definitions will apply:

3.1 **Civilian Component.** The civilian personnel accompanying a force of a Participant who are in the employment of the armed services of that participant.

3.2 **Commander (Name of Force).** The General Officer Commanding (*Name of Force*).

3.3 **Established Post.** Means those posts within the MMU that are designated by the Participants on the current MMU Operational Establishment.

3.4 **Financial Management Group (FMG).** The FMG will be comprised as follows: (define the management group taking into consideration the Command Group, number of Participating Nations etc.).

3.5 **LSSS.** Food, water, billeting, transportation (including airlift), petroleum, oils, lubricants, clothing, communication services, medical services, ammunition, base operation support (and construction incident to base operations support), storage services, use of facilities, training services, spare parts and components, repair and maintenance services (including recovery), airport, and seaport services. Also includes the temporary use of general-purpose vehicles and other non-lethal items of military equipment.

3.6 **Lead Nation (LN).** One of the participant nations will be designated as the LN for the MMU. The LN will normally provide the majority of the infrastructure (including medical equipment) for the MMU. The precise provision will be agreed within the IAs, which will be pursuant to this MOU for each operation. The designated LN will in all cases provide the Commanding Officer for the initial deployment of the MMU.

3.7 **Commanding Officer (CO).** The Commanding Officer of the MMU.

3.8 **MMMSG.** Multinational Medical Management Steering Group. See paragraph 5.1.

3.9 **(Name of Force) Medical Advisor.** The Principal Medical Advisor to the General Officer Commanding (*where*).

3.10 **National Medical Contingent (NMC).** A generic term for those personnel from one of the Participants assigned to the MMU, to include all healthcare professionals, administrative and support staff.

3.11 National Senior Medical Officer (SMO). The Senior Medical Officer for each Participant as appointed by each Participant's National Contingent Commander.

3.12 National Contingent Commander. The Senior Officer for each Participant will be the National Contingent Commander for that Participant.

#### **SECTION FOUR - COMMAND AND CONTROL**

4.1 The NMCs form a part of a Participant's contribution to (*Name of Force*). Full Command of NMCs remains with national authorities. Operational Command (OPCOM) if ceded, or Operational Control (OPCON) of the MMU resides with the Commander of (*Name of Force*).

4.2 Tactical Control (TACON) of the MMU will be exercised by the CO.

4.3 Local Administrative support of NMC personnel (for feeding, accommodation, medical/dental care and transportation) will be exercised by the CO. NMCs will remain under national arrangements for wider aspects of administrative command (pay and allowances, welfare, honors and awards).

#### **SECTION FIVE - ORGANIZATION AND MANAGEMENT**

5.1 Background. The MMMSG is a high level Steering Group representing the Participants in the development and operation of the MMU in *Location*, and comprised as specified in paragraph 5.8. A MMMSG is not a permanent capability. Rather, it may be formed when a MMU is being planned and implemented. It provides guidance when initialing planning an MMU and then provides oversight once the MMU is established and in operation.

5.2 Purpose. MMMSG is responsible for determining, establishing and enforcing the clinical standards, professional protocols and manning levels for the MMU.

5.3 Tasks. The MMMSG will audit, evaluate and manage the MMU and provide direction in the following areas:

- a. Manning;
- b. Guidelines, protocols;
- c. Clinical standards;
- d. Clinical tasks;

- e. Patient complaints;
- f. Administration;
- g. Medical supply;
- h. Medical equipment scaling; and
- i. Life support and health services support reports and returns.

5.4 Authority. MMMSG members act with the authority of their respective Participants and are empowered to sanction changes of substance to the MMU.

5.5 Working Groups. The MMMSG is authorized to convene working groups, as it may consider necessary to further its purpose.

5.6 Changes. Changes of substance to the MMU can only be decided and implemented on a basis of consensus amongst all Participants.

5.7 Composition. The Participants will provide the Chairman and Secretary of the MMMSG on a continuous, rotational basis, as follows:

- a. From the date this MOU comes into effect until Date - Participant;
- b. From Date to Date - Participant; and
- c. From Date to Date - Participant.

If required, the rotation will be repeated, as necessary. *(If more than three nations are participants, the additional participants are added to the rotation). Terms of reference for the chairman and secretary are to be developed.*

5.8 Membership will include the following, and such other personnel as are required for the efficient conduct of business, which may be invited to attend as determined by the Participants:

- a. *Nation: National Representing Body*
- b. *Nation: National Representing Body*
- c. *Nation: National Representing Body*
- d. *Force: Force Medical Director*
- e. MMU: CO (ex officio)

5.9 Method of Operating. The MMMSG will meet at least twice per annum, or as directed by the Chairman. Participants are responsible for bearing their own attendance costs. All meetings will have Minutes, and copies supplied to all members.

## **SECTION SIX - JURISDICTION AND DISCIPLINE**

6.1 While participating in this MOU in the country of *Location*, the personnel of each of the Participants will be under the exclusive jurisdiction of their national elements, as specified in the Military Technical Agreement between *Force* and the *Host Nation of Date*, and *(insert other agreements)*.

6.2 Any allegation that a member of a NMC has committed a criminal or disciplinary offence will be brought to the attention of the CO and the appropriate Commander NMC. Investigations will be carried out by the investigating bodies of the NMC concerned in accordance with the relevant national procedures of the NMC.

## **SECTION SEVEN - PROFESSIONAL MEDICAL CONSIDERATIONS**

7.1 Organization and Rotations. Participants will contribute appropriately qualified and registered healthcare personnel to the MMU by allocation of posts to the military forces or civilian components of the Participants on a basis decided by the Participants, in accordance with the MMU Operational Establishment. The MMU post of Commanding Officer will be held by *Lead Nation* on a standing basis. Other MMU posts can be filled, on a rotational basis, as determined by the Participants.

7.2 Cross training and exchange will, where possible, take place in the Lead Nation prior to deployment to the MMU in order to develop interoperability of personnel and understanding of Lead Nation's procedures, equipment and doctrine. The details concerning pre-deployment activities, if appropriate, will be detailed in the relevant IA.

7.3 Prior to deployment, the MMU or the national contributions to the MMU should be evaluated in accordance with STANAG 2560, AMedP-1.6 *Medical Evaluation Manual*, unless operational necessity prevents such an evaluation.

7.4 Duty Rosters and working hours will be at the direction of the CO in consultation with the Commanders NMC.

7.5 Embedded Elements. A NMC may include embedded elements of personnel from other nations, the responsibilities for which are addressed in separate arrangements between a Participant and those nations and requires the full agreement of all Participants.

7.6 Credentialing and Privileging of Clinical Personnel. Medical functioning and treatment of patients by a multinational medical staff will be underpinned by relevant

NATO Standardization Agreements (STANAGs), direction from the MMMSG or guidance provided for the specific theatre in which the MMU is deployed.

7.7 As per STANAG 2552, each Commander NMC will be required to confirm that all healthcare providers possess the appropriate credentials required. The Lead Nation shall ensure that terms of reference for all clinical positions include credentials required for the position.

7.8 Members of Participants may be required to work alongside health professions that are not recognized in the clinical practice of all of the Participants. Individual health professionals will be expected to practice within the spirit of this MOU but cannot be compelled to accept clinical direction from those professions that have no recognized specialty/training program within their own country. Where such concerns exist, individual health professionals must raise the issue with their Commander NMC who will consent to local arrangements with the CO MMU as required. If any doubt exists, the guidance of the MMMSG will be sought.

7.9 The employment of personnel not belonging to, or employed by, the armed forces of the Participants is not included within the remit of this MOU. The employment of such personnel will require the consensus of the Participants.

7.10 Standards. Treatment of patients from Participating nations by a multinational medical staff will be underpinned by extant NATO medical publications. Additionally, to ensure appropriate peacetime standards of care, where practicable, and to provide a common working environment, clinical protocols and guidelines, determined by the LN in consultation with Participants and established by the (*Name of Force*) MMMSG, will be applied.

7.11 Immediate Response Team (IRT). An IRT will be deployed by dedicated Forward Aeromedical Evacuation aircraft, as directed by (*Name of Force*) Medical Director. It will be manned, maintained and operated with the intention that the maximum lapse of time from tasking of the IRT to delivery of the casualty will, wherever possible, meet (currently accepted) clinical timelines. It is accepted, however, that the achievement of this target cannot be guaranteed.

7.12 Quality Assurance. The delivery of medical care services will be subject to Continuous Improvement in Healthcare Support to Operations (CIHSO) audit undertaken through the (*Name of Force*) Medical Advisor and the responsible Joint (Task) Force Command Medical Advisor.

7.13 Medical Repatriation. Strategic Aeromedical Evacuation will remain a national responsibility, although this may be achieved through reciprocal arrangements on a bilateral or multi-lateral basis. Medical evacuation may be achieved through a formal coalition Evacuation and Repatriation Plan developed for a specific operation as articulated in the relevant IA.

7.14 Clinical Records. The legal holder of MMU clinical records will be:

- a. For a patient from a Participant nation: the MMU on behalf of the Participant nation; after one year, the clinical records will revert to being the property of the Participant nation;
- b. For a patient from a non-participant NATO nation, or from a non-NATO nation: the MMU;
- c. For local civilians: the MMU; and
- d. For Participants' civilian contractors: in accordance with national practice.

7.15 Records will be maintained in format according to national ownership and as locally determined by the Participants. With the exception of paragraphs 7.14 b. and c., once the patient care episode has been completed, the Participants, in accordance with national practice, will retain records. In the case of litigation, upon request, the defense of the accused should have access to all relevant material including clinical records.

7.16 Medical Confidentiality. Medical confidentiality will be maintained in theatre in accordance with the national law and practice of the patient concerned and the treating clinician. In general, this means the relationship between treating clinicians and their patient will remain one of confidence. Clinical information will be shared with other treating health professionals only, except when a patient has expressly consented to its being shared more widely.

7.17 MMU Support. Detailed guidance and instructions regarding MMU support (including information on organization, personnel, equipment, security, reporting and Terms of Reference) will be contained in the relevant IA.

7.18 Oversight. There will be three components to the oversight of the MMU:

- a. Strategic level oversight, which will be provided by MMMSG;
- b. Operational level oversight (how medical capability is delivered within the Area of Operations) which is the responsibility of the *Name of Force* Medical Advisor; and
- c. Tactical level oversight (activities within the MMU). The aim is to identify trends and episodes that can be used to identify lessons learned in order to improve procedures, services and outcomes. It has two components:
  - (1) Audits. Audits form an essential part of the concept of CIHSO and will identify both positive and negative trends in a timely manner; and

(2) Individual Case Analysis. Analysis of individual cases can produce valuable lessons. Such cases can be identified both from within and outside the MMU.

7.19 Tactical oversight of the MMU will form an external part of quality control and assurance and will be undertaken actively by the following team: *(provide description of team members and oversight)*.

7.20 The findings of the Clinical Oversight Committee will inform the decision making process of the MMU. The Committee will be able to make recommendations concerning clinical/service procedures but will have no formal executive authority to enforce change.

## **SECTION EIGHT - LOGISTIC AND OTHER SUPPORT**

8.1 For the purposes of this MOU all equipment and LSSS will be considered multinational assets and therefore be subject to cost sharing as of the date this MOU comes into effect. Participants who provide equipment to the MMU will retain responsibility for arranging the maintenance of that equipment. The associated costs of such maintenance will be subject to reimbursement through the NATO Common Funding Mechanism, if appropriate.

8.2 Logistic support for the MMU falls into three primary categories, Medical Logistics, General Logistic Support and Individual Logistic Support.

- a. Medical Logistics Support. The Lead Nation will coordinate medical logistics support from their own nation, an agency such as NSPA, a Role Specialist Nation, or a combination of the above.
- b. General Logistics Support. General logistics support refers to the provision of Base Support Operations such as meals, water, billeting, bath/shower, laundry support, and quality of life facilities as detailed within the IA.
- c. Individual Logistics Support. The provision of individual logistic support covers the provision and maintenance of items such as uniform, weapons, postal services and welfare. This will be provided by each Participant at a quality consistent with such services provided to their own forces when deployed in national units. Another Participant may provide individual Logistic Support where appropriate bi- or multi-lateral agreements or arrangements already exist.

8.3 The procedures used for requesting LSSS between MMU and the Participants will be in accordance with NATO Logistic Policy (MC 319) as follows:

- a. Requesting Participant. The Requesting Participant will request logistic

support, supplies and/or services using the standard NATO order form (Annex B to STANAG 2034) and submitting the same to the CO for furtherance to the supplying Participant. Requests for major/capital medical equipment are to be forwarded, via a Participant's POC, to the MMMSG for approval;

- b. Supplying Participant. If services or items cannot be provided, the order form will be returned promptly by the Supplying Participant to the Requesting Participant with a statement of explanation for the inability to deliver the LSSS; and
- c. Points of Contact (POC). The Participants will provide, to each other, positions of those personnel authorized to approve, place and accept orders, as follows:
  - (1) *Nation: Contact.*
  - (2) *Nation: Contact.*
  - (3) *Nation: Contact.*

## **SECTION NINE - FINANCE**

9.1 Participants will be individually responsible for payment of:

- a. With respect to its forces, including the civilian component, and his/her personal property, individual Participants will retain responsibility throughout the period of exchange for all pay, allowances, services, benefits, indemnities, reimbursements, and other particulars for which each Participant is financially responsible under the laws and regulations governing them;
- b. All costs, including accommodation, travel and other expenses arising out of business performed by their forces, including the civilian component, away from the MMU in accordance with the regulations of the responsible Participant; and
- c. All costs arising from the deployment of their forces, including the civilian component, to and from the MMU in accordance with the regulations of the responsible Participant.

9.2 *Lead Nation* will be designated by this MOU, and therefore will pre-fund all multinational-shared costs and will seek reimbursement under NATO Common Funding in accordance with SG(2006)0160 – Rev 1 for the costs eligible under that mechanism.



Eligible expenses for NATO Common Funding are listed in Annex B. Expenses not covered under NATO Common Funding may be brought to the FMG by the Participant for consideration by the Lead Nation, and if deemed acceptable, the Lead Nation will invoice other Participants on a quarterly basis. Each Participant will pay the invoice within 30 days of receipt. Invoices will be forwarded to the POC as per 9.10. All records of transactions will be maintained and made available for review by each Participant as requested.

9.3 Duration of Lead Nation / Functional lead Nation Role. As per PO (2005)0098, to be eligible for reimbursement, the LN role must be assumed for a period of at least one year. Additionally this declaration should be included in the respective FORCEREP by the respective nations.

9.4 Base Support Operations Costs. The Lead Nation will have primary responsibility for the provision of logistic support, services, and supplies for the MMU for which it will be reimbursed through the NATO Common Funding MOU mechanism, or by the other Participants in accordance with existing arrangements or agreements or the relevant IA.

9.5 MMU Supplies and Services. The Lead Nation, on a fee for service basis, may charge user nations or agencies for mutually determined goods and services that are directly attributable to patient care provided at the MMU to the users. This will not include charges for personnel costs or capital items. The costs of patients from other coalition or allied States will be borne by the Lead Nation, which will be responsible for recovering the costs from the government of the patient concerned. Where nationality cannot be established (including Prisoners of War, detainees and displaced civilians), the costs will be shared equally between the Contributing Nations. Cost sharing/reimbursement arrangements related to the provision of patient care will not include any labor costs.

9.6 Non-Attributable Costs. Operations and Maintenance (O&M) costs for equipment and consumables in the MMU, which cannot be related to a specific Participant, will be apportioned on a 'cost share' based upon the percentage of manpower that each nation has contributed to the *Name of Force*.

9.7 Equipment Costs. Where the purchase of equipment falls exclusively to one Participant, the supplying Participant may recover incremental costs for additional expenses incurred as a result of damage to equipment caused by the receiving Participant. This provision does not apply to reasonably expected wear and tear.

9.8 Property and equipment acquired through NATO common funding will become NATO property and will be accounted for in NATO property accounts as temporarily issued to the agency providing the support. NATO will retain ownership and rights to residual value of any property funded through NATO budgets or programs.

9.9 All multi-national shared costs will be controlled by the FMG, which has authority and responsibility for:

- a. Providing national scrutiny of all multinational-shared costs to support MMU;
- b. Approving estimates of all multinational shared costs including in the Annual Budget Estimate proposals prepared in accordance with para 9.8;
- c. Obtaining national approval, where necessary, of proposal annual Budget Estimates and any in year amendments, thereto;
- d. Obtaining where necessary, direction or approval from national authorities to permit expenditures in support of MMU not already provided for in an approved Annual Budget Estimate or amendment and for which they do not already have approval authority in accordance with national financial regulations; and
- e. Controlling all multinational-shared costs.

9.10 Without prejudice to the provisions of Section 12, any financial or contractual dispute between Participants will be referred initially to the FMG for resolution.

9.11 The financial year will commence on 1 April of each year.

9.12 The FMG will prepare the annual budget estimate and support the MMU, and let and administer all contracts on behalf of MMU. The accounts will be available for inspection by Participants.

9.13 Lead Nation will provide financial management information and secretarial support requested by the MMU free of charge, but reserves the right to charge for additional information required by individual Participants on an incremental cost only basis.

9.14 All transactions relating to this MOU will be settled by payments in cash in currency specified by the FMG at the beginning of each financial year. The General Accounting Rate (GAR), the standard rate of exchange used by the Lead Nation, will be used when converting currency for billing purposes. The GAR to be used is the rate as at the date of the invoice.

9.15 All assets jointly acquired under this MOU will be disposed of in a manner as mutually determined by the Participants. Equipment provided by Participants prior to the entry into effect of this MOU, will remain the property of the Supplying Participant, who will decide their disposal policy for such equipment.

9.16 POCs for Financial Matters are:

- a. For Nation: Contact;
- b. For Nation: Contact; and

- c. For Nation: Contact.

9.17 Participants will promptly notify the other Participants if available funds are not adequate for the implementation of this MOU. If a Participant notifies the other Participants that it is terminating or reducing its funding, all Participants will immediately consult with a view towards continuation on a changed or reduced basis. If this is not acceptable to all Participants, then the provisions of Section 14, Duration, Withdrawal and Termination will apply.

## **SECTION TEN - CLAIMS**

10.1 Each Participant will waive all claims against the other in respect of injury or death of any of its officers, employees or agents (which do not include contractors) or loss or damage to its property caused by the acts or omissions of the other Participant, its officers, employees or agents in connection with this MOU and its IAs.

10.2 Claims alleging medical professional negligence will be the responsibility of the implicated Participant. Medical professional negligence is failure of medical personnel to exercise the degree of care and skill that a medical practitioner of the same medical specialty would reasonably be expected to use under similar circumstances. For the purpose of this MOU, medical professional negligence claims include claims resulting from reckless acts or reckless omissions, willful misconduct, or gross negligence of a Participant's personnel or agents (which do not include contractors), while in the performance of duties as medical clinicians under this MOU.

10.3 With respect to third party claims:

- a. Each Participant will be responsible for the settlement of third party claims arising from the acts or omissions of its officers, employees or agents (which do not include contractors) as a consequence of the performance of official duties in connection with this MOU or any IAs;
- b. Where both/all Participants are responsible for the settlement of the claim, or it is not possible to attribute responsibility, the Participants will confer with a view to resolving the claim, and if required, apportioning responsibility in satisfaction of the claim; and
- c. In the event that one Participant receives notice of such claims, the receiving Participant will inform the other Participant as soon as practicable. The Participants will assist each other in the procurement of evidence related to such claims.

10.4 Notwithstanding paragraph 10.1, if injury, death, damage, or loss, incurred by any Participant or a third party, results from reckless acts or reckless omissions, willful

misconduct, or gross negligence of a Participant, its officers, employees and agents (which do not include contractors), the cost of any liability will be borne by that Participant alone.

10.5 Claims arising under any contract awarded pursuant to this MOU and its IAs will be resolved in accordance with the terms of that contract. The Participants will not indemnify contractors against liability claims by any other persons.

10.6 For claims arising between participants, the provisions of Article VIII of the Agreement between the Parties to the North Atlantic Treaty Regarding the Status of Their Forces, done 19 June 1951 (NATO SOFA), will be applied *mutatis mutandis*.

## **SECTION ELEVEN - SECURITY**

11.1 All classified information exchanged or generated in connection with this MOU will be used, transmitted, stored, handled, safeguarded and disposed of in accordance with the Participants' applicable national security laws and regulations, to the extent that they provide a degree of protection no less stringent than that provided for NATO classified information as detailed in the document "Security Within the North Atlantic Treaty Organization," C-M (55) 15 (Final), dated 15 October 1997 and subsequent amendments.

11.2 Classified information will be transferred only through Government-to-Government channels or through channels approved by the Designated Security Authorities of the Participants. Such information will bear the level of classification and country of origin.

11.3 Each Participant will take all lawful steps available to it to ensure that information provided or generated pursuant to this MOU is protected from further disclosure without the originating Participant's consent to such disclosure. Accordingly, each Participant will ensure that:

- a. The recipients will not release the classified information to any national organization or other entity of a third party without the prior written consent of the originating Participant;
- b. The recipients will not use the classified information for other than the purposes provided for in this MOU; and
- c. The recipient will comply with any distribution and access restrictions on information that is provided under this MOU.

11.4 The relevant Participants will investigate all cases in which it is known, or where there are grounds for suspecting, that classified information provided or generated pursuant to this MOU has been lost or disclosed to unauthorized persons. Where appropriate, the relevant Participant will take disciplinary action against those responsible

for loss or disclosure. The relevant Participant will also, where appropriate and permissible, promptly and fully inform the other Participants of the details of any such occurrences, and of the final results of the investigation and of the action taken to prevent recurrences.

11.5 All visiting personnel will comply with the security regulations of the MMU, as designated by the Lead Nation. Any information disclosed or made available to visitors will be treated as if supplied to the Participant sponsoring the visiting personnel and will be subject to the provisions of this MOU.

## **SECTION TWELVE - DISPUTES**

12.1 Any dispute regarding the interpretation or application of this MOU will be resolved between the Participants at the lowest possible level. Disputes not resolvable at the lowest possible level will be resolved through consultation between the Participants up to, and including, MMMSG and will not be referred to any national or international tribunal or any other third party for settlement.

## **SECTION THIRTEEN - ADMISSION OF NEW PARTICIPANTS**

13.1 The Participants will recognize that other nations may wish to join the MOU. Participation will be permitted only in accordance with the provisions applicable to the existing Participants and with full written acceptance of the existing Participants.

## **SECTION FOURTEEN - DURATION, WITHDRAWAL AND TERMINATION**

14.1 This MOU will come into effect upon signature of all Participants.

14.2 This MOU may be terminated at any time by mutual consent of the Participants. Any Participant may withdraw from the MOU by providing 90 days written notification to the other Participants. In the case of withdrawal of a Participant, the remaining Participants will consult regarding the continuation of the MOU.

14.3 In the event of withdrawal or termination:

- a. The provisions of Section 9 (Finance) and Section 10 (Claims) will remain in effect until all outstanding payments and claims are finally settled; and
- b. The provisions of Section 11 (Security) will remain in effect until all such information and material is either returned to the originating Participant or destroyed.

14.4 Where possible, the Participants will consult each other over the preparation of any National plans that may have an impact on the deployment of the Participants forces to the MMU.

**SECTION FIFTEEN - AMENDMENT**

15.1 This MOU may be amended at any time, in writing, by the mutual consent of the Participants. Amendments will be effected by exchange of message or letter and will be numbered consecutively.

**SECTION SIXTEEN - SIGNATURE**

16.1 The foregoing represents the understandings reached between the Ministry of Defence of Nation, the Minister of Defence of Nation and the Ministry of Defence of Nation upon the matters referred to therein.

16.2 Signed in triplicate in the English language.

For the Ministry of Defence of Nation	For the Ministry of Defence of Nation	For the Ministry of Defence of Nation
Rank	Rank	Rank
Title	Title	Title
Date	Date	Date
Location	Location	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ANNEX B: MOU TEMPLATE FOR LEAD NATION RESPONSIBILITIES AND  
APPLICATION FOR NATO COMMON FUNDING FOR A MULTINATIONAL MEDICAL  
UNIT**

**THE MINISTER OF DEFENCE OF *[LEAD NATION]*  
AND**

**SUPREME HEADQUARTERS ALLIED POWERS EUROPE  
(SHAPE)**

**REGARDING**

**LEAD NATIONS RESPONSIBILITIES  
AND ASSOCIATED FINANCIAL AND ADMINISTRATIVE PROVISIONS FOR THE  
ROLE *[X]* MEDICAL TREATMENT UNIT (MMU) AT *[LOCATION]***

## Preamble

Noting that the United Nations Security Council Resolution (UNSCR) [*Resolution and Date*], authorized the establishment of [*Force*] in order to assist in the maintenance of security in [*Location*], so that the [*Host Nation*] Interim Authority as well as the personnel of the UN could operate in a secure environment;

Noting that subsequent UNSCRs have expanded and extended the mandate, both geographically and temporally;

Noting that the North Atlantic Treaty Organization (NATO) took the lead of [*Force*] on [*Date*];

Noting the SHAPE OPLAN [*OPLAN Number*] approved by the North Atlantic Council by [*Document Number*] dated [*Date*];

Noting the provisions of (Revised Funding Provisions for [*Force*] dated), which provides a framework whereby a Lead Nation offering to operate a NATO Role [*1, 2 or 3*] Medical Treatment Unit (MMU) for the minimum prescribed period of 12 months under NATO command and control, would be eligible for reimbursement of certain categories of costs either from NATO or from the nations using the services offered as detailed in this MOU;

Considering the offer of the government of [*Nation*] to act as Lead Nation (LN) for the Role [*1, 2 or 3*] Medical Treatment Unit (MMU) at [*Location*] for an initial period of 12 months from Transfer of Authority (TOA) to NATO as indicated in the relevant FORCEPREP/TOA Message; and

Recognizing the need to formalize provisions establishing responsibilities of the designated Lead Nation, and the underlying financial and administrative procedures associated with implementing such an arrangement;

THE PARTICIPANTS HAVE REACHED THE FOLLOWING UNDERSTANDING:

## SECTION 1

### Definitions

1.1. **Lead Nation (LN)** means the nation who is the nation assuming functional responsibility for organizing, maintaining and coordinating the determined minimum military requirement capability as included in the [*Force*] Combined Joint Statement of Requirements (CJSOR) and Theatre Capability Statement of Requirements (TCSOR), with the understanding that the capability itself may well be provided multinational, or by framework nations or multinational framework organizations, and that its composition may change over time.



1.2. **Functional Lead Nation (FLN)** means the nation or agency who is in whole or in part responsible for providing Role [1, 2 or 3] level of medical support to NATO, NATO forces, and non-NATO forces authorized to participate in [Force] operations who will be based at, or transit through, the [Location]. The inventory of specific functions collectively comprising the MMU capability, which is proposed as eligible for either total or prorated common funded reimbursement, is listed at Annex C.

1.3. **Medical Treatment Facility (MTF)** *[this para should be expanded upon to describe the capabilities of the facility, and will be dependent on the role]* The capacity will be sufficient to allow diagnosis, treatment and holding of those patients who can receive adequate treatment and be returned to duty within [Location] Area of Operations, dependent on the Theatre Holding Policy.

1.4. **User** means any military or civilian personnel from NATO and Non-NATO Troop Contributing Nations, who require and will receive Role [1, 2 or 3] level of medical support from the MMU at [Location]. LN or FLNs will treat (in accordance with the mission therein) the following:

- a. All military and civilian personnel from NATO, including NATO Support and Procurment Agency (NSPA), NATO C3 Agency (NC3A) and Non-NATO Troop Contributing nations deployed on operations in support of [Force] including coalition forces;
- b. All UN, governmental and non-governmental organizations and other agencies' personnel who are authorized by HQ [Force] to receive treatment from NATO; and
- c.
- d. Other persons requiring treatment IAW [Force] Medical Rules of Eligibility.

1.5. **Support** means the provision of all possible levels of support available at the Role [1, 2 or 3] MMU to be provided to users based on clinical need and consistent with NATO doctrine.

1.6. **[Force]** means [Name of Force in full].

1.7. **Expenses** means those expenditures associated with the establishment, support and sustainment of national, multinational or international headquarters, forces or formations. For the purposes of this MOU and its supporting documents:

- a. NATO Common Costs are those expenses determined in advance to be the collective responsibility of the Alliance and eligible for NATO funding in accordance with the SG(2006)0160-REV1; and
- b. Direct Nation or Agency Borne Costs are those expenses considered as the responsibility of the respective sending nations or agencies, which are

ineligible for NATO common funding, paid directly to the LN or service providers via a specific or drafted reimbursement mechanism.

## **SECTION TWO**

### **Purpose**

2.1. The purpose of this MOU is to set out the responsibilities of the LN and to establish policy, procedures and responsibilities for the funding and financial administration of the medical services provided by the LN to NATO and other users.

## **SECTION THREE**

### **Scope and General Provisions**

3.1. This MOU is intended to be in accord with PO (2005)0098 (Revised Funding Policy for non-Article 5 NATO-led Operations dated 18 October 2005) and SG (2006)0160-REV1 dated 25 July 2006, which establishes an eligibility framework whereby a LN operates a Role [1, 2 or 3] MMU subject to reimbursement of certain categories of costs by either NATO or nations whose personnel utilize the services provided. In the context of medical treatment facilities (which have been specified as eligible for common funding), these would be assembled and maintained by a LN with certain costs as detailed in this MOU and reimbursed by NATO Common funding and user nations or agencies.

3.2. This MOU sets out an umbrella arrangement providing structure for the medical support provided to NATO personnel and other users.

3.3. The services provided by the LN will be available to all NATO personnel and other users' personnel under equal conditions and costs. All facilities supported by NATO common funding will be available for use by all nations participating in the [*Force*] mission under equal terms and reflecting paras 1-4 and 1-5.

## **SECTION FOUR**

### **References**

4.1 The documents which apply to this Arrangement are contained at Annex A to this MOU.

## **SECTION FIVE**

### **Responsibilities**

5.1. The LN is responsible for the provision of the medical support functions at *[Location]* as detailed at Annex C to this MOU under the reimbursement provisions indicated in this MOU. In addition, the LN is responsible for publishing administrative regulations and implementation procedures applicable to the services available. Additionally, Technical Arrangements (TAs) will be developed by the LN with those nations (FLNs/ Role *[1, 2 or 3]* MMU TCNs, agencies) that have been given certain functional units of the MMU to operate and man or to contribute with specialized personnel to functional units to ensure medical capabilities provided and maintained. These TAs will cover the details applicable to the various support functions/services. Such TAs are to be compliant with the principles and framework established by this MOU. SHAPE will arrange for the detailed financial implementing procedures applicable to the LN/FLNs for the reimbursement of costs eligible for common funding.

5.2. The LN and FLNs will provide medical treatment based on clinical need to all NATO military and civilian personnel (including NATO International Civilians, International Civilian Consultants and civilian Voluntary National Contributions) receive full medical support. deployed to support the *[Force]* mission and other users within existing capabilities and means as set out in *[Force]* Medical Rules of Eligibility and ACO Medical Advisor's Directive 83-1, to the same standards and at the same levels as provided to their own personnel at Role *[1, 2 or 3]* facilities. Medical treatment for non-NATO personnel should be defined in the Medical Rules of Eligibility but are generally:

- a. Foreign nationals who are members of the International Community (IC) receive emergency care. Providing care beyond emergency care is either defined in bi-lateral and national agreements or to be decided upon on a case-by-case basis by the respective nations or contractors.
- b. Local nationals should be referred to the local health care system whenever possible. Life, Limb or Eyesight (LLE) care may be provided within means and capabilities if local medical care is not available.

5.3. The LN will continue to provide all reasonable medical and related information concerning NATO personnel to SHAPE via MEDSITREPS and EpiNATO reports. The LN will continue to provide national command elements and/or organizational authorities with medical information of respective personnel treated. Such information may include identity, medical and related records of the treatment at the Role *[1, 2 or 3]* MMU taking into account medical confidentiality.

5.4. The LN, together with other FLNs/TCNs, will provide the predetermined and required manning to run the MMU facility in line with the needs of the operation.

## **SECTION SIX**

### **Financial Provisions**

6.1. Annex B to this MOU lists the details of the inventory of Role [1, 2 or 3] MMU functions which are eligible for NATO common funding.

a. Eligible costs for NATO common funding. The costs that are identified to be the responsibility of NATO will be reimbursed on the basis of presentation of invoices and supporting documentation of the actual direct, incremental costs incurred by the MMU. The details of the eligible costs are included in Annex B to this MOU.

Principally:

(1) Military Budget will cover the following:

- (a) Transportation of equipment to and from theatre;
- (b) Deployment and redeployment of personnel, up to two rotations per year; and
- (c) In-theatre operation and maintenance (O&M) costs, including facility maintenance, Biomedical Equipment Technician and repair and the cost of locally hired personnel.

(2) NATO Security Investment Program (NSIP) will cover the following:

- (a) In-theatre infrastructure needed to maintain the minimum military requirement and assuming maximum use of existing facilities;
- (b) De-mining for the capability footprint;
- (c) Static force protection;
- (d) Operation-specific additional NBC equipment not ordinarily part of the basic capability or unique to the operation; and
- (e) CIS and intelligence database equipment for connectivity with the theatre HQ.
- (f). Direct and Nation or organization borne costs comprising all other related cost, which are considered as the responsibility of the respective sending nations or organizations, are not included in the eligible costs for NATO common funding such as specific medical equipment, medical supplies and blood replacement as set out in this MOU. All user nations or agencies accept the liability to reimburse the

direct and nation or organization borne costs that are ineligible for NATO common funding. Nation-borne costs are administered directly between the LN/FLN and the nation concerned, without NATO pre-financing or administration.

6.2. The LN, on a fee for service basis, may charge user nations or agencies for medical treatment provided at the Role [1, 2 or 3] MMU to the users. This will not include charges for personnel costs or capital items. Users will not be personally charged or responsible for this treatment. The LN (or NSPA, while assuming LN responsibilities when some of the Role [1, 2 or 3] MMU functions are being provided through outsourcing) pending the approval of the respective Committees, may bill the individual nations for medical treatment and/or consumables provided to their personnel. Responsible national authorities, user nations and agencies will reimburse the LN, if billed, for services provided to their personnel.

6.3. The availability of NATO common funding is subject to approval of the requisite budgets and/or projects by the appropriate NATO funding committee. The LN will collaborate with SHAPE or its designee, and any functional lead nations (FLNs) or agencies, to develop the necessary cost data details to support the associated NATO funding requests. If required, the LN will provide technical experts to assist SHAPE in defending the funding request before the appropriate funding committee.

6.4. The LN will consolidate cost reports and reimbursement requests from FLNs, certify performance of services, and forward consolidated invoices on a monthly basis to SHAPE or its designated HQ to be processed in line with this MOU and the detailed implementing procedures. Supporting documentation for any expenditure funded or reimbursed through NATO common funding is subject to audit by the International Board of Auditors for NATO, the ACO Audit and Inspection Branch or other individuals designated by the Theatre Financial Controller.

6.5. All unserviceable equipment should be repaired or replaced without delay. If damaged equipment prevents delivery of primary surgery, immediate action should be undertaken to restore primary surgery capability.

6.6. The delivery of medical care services is subject to Healthcare Quality Assurance audit undertaken through the [Force] Medical Director, responsible Joint (Task) Force Medical Adviser, and the ACO Medical Adviser.

## **SECTION SEVEN**

### **Equipment and Infrastructure**

7.1 Existing moveable property: The equipment of the Role [1, 2 or 3] MMU will comprise all material and equipment from the previous and existing Role [1, 2 or 3] MMU, excluding

assets purchased by NATO or the LN temporarily located at the facility. Upon closure of the MMU or termination of this MOU, the Participants and NATO will settle by negotiation the residual value of such property in accordance with existing NATO rules and procedures. Wherever practical, any equipment originally contributed without charge by a participant or user will revert to the participant or user who provided the equipment. Any NATO-provided equipment will remain the property of NATO and be redistributed in accordance with standard NATO procedures.

7.2. Property and equipment acquired through NATO common funding will become NATO property and will be accounted for in NATO property accounts as temporarily issued to the agency providing the support. NATO will retain ownership and rights to residual value of any property funded through NATO budgets or programs.

7.3. NATO-funded property and equipment will not be utilized for non-NATO operations, exercises or other purposes without the specific prior authorization of DCOS SPT SHAPE or their designees.

## **SECTION EIGHT**

### **Claims**

8.1. Participants will waive non-contractual personnel or property damage claims against one another arising from activities conducted pursuant to this MOU as specified in Article VIII, paragraphs 1-4, of the NATO SOFA.

8.2. In accordance with Section 3, paragraph 10, of the Military Technical Arrangement, as referenced at Annex A, Participants and users will not be held liable for any damage to civilian or *[Host Nation]* Government property arising from activities conducted pursuant to this MOU.

8.3. For claims not covered by 8.1 or 8.2, regardless of provisions for potential reimbursement of the costs of various functions, each nation or agency at *[Location]* will be responsible for resolution and payment of claims arising from the acts and omissions of their personnel or personnel assigned to organizations for which they are the lead agency. The Participants, and users as appropriate, will negotiate cost sharing of claims determined to be the responsibility of more than one participant or user.

8.4. Liability for malpractice and resultant damage will be covered by the same rules applicable within the NATO SOFA.

## **SECTION NINE**

### **Commencement, Duration Withdrawal and Termination**

9.1. This Arrangement will become effective on the date of the last signature thereof while the financial aspects of the MOU will be applicable from the TOA, as indicated in the relevant FORCEPREP/TOA message, while meeting the conditions included in Annex B of this MOU for the reimbursement to the LN and the Full Operation Capability (FOC) requirements set out, subject to approval of the respective Committees.

9.2. This MOU is intended to cover the period of 12 months after FOC as set out in article 9.1 above and may be extended as agreed thereafter by mutual agreement of the parties. The objective is for this MOU to be used by all nations as they assume LN responsibilities for the Role [1, 2 or 3] MMU at [Location].

9.3. This Arrangement will remain in effect until such time as a Participant informs the other in writing six months (180 days) in advance of its wish to withdraw its cooperation. The Arrangement may be terminated by the Participant's mutual written consent, effective immediately, at any time.

9.4. Any responsibilities incurred by a Participant during the active period of this Arrangement will remain that Participant's responsibility until fulfilled, notwithstanding withdrawal, termination or expiry of this MOU. All pending financial issues should be resolved through consultation between the Participants.

## **SECTION TEN**

### **Modification and Interpretation**

10.1. Any dispute, which may arise in the context of cooperation under this MOU, as a result of the interpretation or implementation of this MOU will be resolved solely through consultation between the Participants. There will be no recourse to any external organization, tribunal or judicial authority, either national or international.

10.2. This MOU may be modified, at any time, with the Participant's mutual written consent.

## **SECTION ELEVEN**

### **Effective Date and Signature**

11.1. This MOU becomes effective on the date of the later signature.

11.2. Signed in duplicate in the English language.

LOCATION, DATE

LOCATION, DATE

For the Supreme Headquarters

For the Minister of Defense

Allied Powers Europe

of *[Lead Nation]*

Appendices:

Appendix 1 – Reference Documents

Appendix 2 – NATO Common Funding Eligible Role *[1, 2 or 3]*

Appendix 3 – Role 3 MTF Functions Matrix

Appendix 4 – Financial Procedure for *[Force]* Related MOU's Respecting Reimbursement to Nations for Theater Level Capabilities Provided to NATO



<p><b>APPENDIX 1 TO ANNEX B: REFERENCE DOCUMENTS [EXAMPLE]</b></p>
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- a. The North Atlantic Treaty, dated 4 April 1949.
- b. Agreement among the Parties to the North Atlantic Treaty and Regarding the Status of their Forces, (NATO SOFA), dated 19 June 1951.
- c. PO (2005)0098, Revised Funding Policy for non-Article 5 NATO-led Operations dated 18 October 2005.
- d. MC 319/1 - NATO Principles and Policies for Logistics.
- e. MC 334/1 - NATO Principles and Policies for Host Nation Support (HNS).
- f. Applicable NATO STANAGs and Policy Directives for Logistics Support, Force Protection and Financial Reimbursement.
- g. AJP-4.5(A) - Allied Joint Publication for Host Nation Support Doctrine and Procedures.
- h. MC 326/2 Medical Support.
- i. AD 83-1 ACO Directive on Medical Support to Operations.

**APPENDIX 2 TO ANNEX B:  
NATO COMMON FUNDING ELIGIBLE ROLE [1, 2 OR 3] MMU  
REIMBURSABLE COSTS**

1. **Preconditions for Eligibility.** A precondition of common funding of a TC-SOR capability is that the Role [1, 2 or 3] MMU capability must be available for use by any NATO forces participating in the operation, and that the function must fall under the operational control (OPCON) of the NATO theatre Commander. The costs must not be attributable to a specific nation; specifically, the costs of consumer logistics services (i.e. medical treatment, messing, and fuel) received should be charged to the nation(s) receiving the service.
2. **Duration of LN/FLNs Role.** As per PO (2005)0098, to be eligible for reimbursement, the LN role must be assumed for a period of at least one year. Additionally this declaration should be included in the respective FORCEREP by the respective nations.
3. **Eligibility: Transportation Costs.** The transportation costs eligible for NATO funding may include:
  - a. One shipment (transportation mode to be determined by NATO) from the national SPOE/APOE to theatre of all equipment not located in theatre by the effective date;
  - b. One return shipment from theatre to national SPOD/APOD (location TBC by SHAPE) of all equipment in theatre to be repatriated at the end of the one year (lead nation) tour of duty; and
  - c. Transport by air of all personnel to theatre, at costs not to exceed commercial air or charter rates on the understanding that NATO common funding will not pay for more than 2 rotations per year. NATO will fund rotation of personnel (including repatriation of one deployer and deployment of his replacement) at six-month intervals. Periodic R&R or home leave trips remain a national responsibility.
4. **Eligibility: Operations & Maintenance (O&M) Costs.** The TC-SOR capability O&M costs anticipated to be eligible for NATO common funding include lease of facilities, utilities costs, cleaning, O&M, minor maintenance, consumable supplies, administrative costs, fuel costs for power generation and local transportation, vehicle maintenance costs, and other administrative costs associated with performance of the function in support of all NATO forces in theater.
5. **Eligibility: Local Hire Costs.** Eligibility of costs in this category include the cost of the local personnel hired to perform functions related to facility operations, security,

cleaning, and other overheads of the TC-SOR functionality. Costs related to all other military or civilian personnel (e.g. salaries, special allowances, per diem, accommodation, food) remain the responsibility of the sending nation.

6. **Eligibility: Contract Support/Outsourced Services Costs.** PO(2005)0098 specifies that the lead nation approach is the preferred option, and mandates that provision of TC-SOR capabilities through outsourcing and/or acquisition requires specific MC and SRB approval. While this provision is not intended to prohibit the use of external commercial support within a framework of lead nation ship, it is aimed at ensuring that force generation remains the primary means of conducting NATO operations. It should also be assumed that any contracts supported through common funding will in due course be subject to NATO procedures for international bidding.

7. **Eligibility: Equipment Acquisition.** The provisions of PO(2005)0098 are not intended to subsidize acquisition of national capabilities; the aim is to reimburse lead nations for the costs of deploying and operating nationally owned capabilities for the benefit of all nations' forces. To this end, acquisition of capital equipment is not expected to be eligible for reimbursement excluding the operation-specific additional equipment not ordinarily part of the basic capability or unique to the operation pending acquisition via the routine operational requirement process as detailed at Reference Q, and IC approval from NSIP funds. Similarly, NATO should not be expected to pay depreciation charges for equipment refurbishment due to normal wear and tear, or for post-deployment refurbishments. When equipment is acquisitioned through common funding, such equipment will be NATO property and will remain in the theatre following rotation of the lead nation.

APPENDIX 3 TO ANNEX B: ROLE 3 MTF FUNCTIONS MATRIX

LINE NO	FUNCTIONS	PRESENT SERVICE PROVIDER	REMARKS	1 January - 31 December 20XX Cost €
<b>ROLE 3 MMR AS OUTLINED IN AJP 4.10 &amp; MC 326 (Note 1)</b>				
1	Command & Control	[LN]/ Military	To include internal communication connectivity via NCN to all in theatre communications and IT systems, in the main rooms (offices, examination rooms, etc) as well as external communication to HQ [Force], all medical facilities, Patient Evacuation Coordination Centre (PECC), etc.	
2	Emergency Surgery	Multinational Medical Unit (MMU)(LN led, Participants)	<b>Primary</b> Surgery directed at repair of the local damage caused by wounding, <b>injury or other cause for surgical intervention</b> . A minimum of 2 surgical teams but definitive number must be determined by the long-term threat assessment. Each surgical team must consist of a General and Orthopedic Surgeon, an appropriate number of Anesthetists and Operating Department Practitioners/support staff. A mission tailored variety of specialist surgeons may include but are not limited to: Urological (desirable), Gynecological, Maxillo-facial surgery, and Ophthalmic surgery and Neurosurgery (preferred, but can also be provided out of theatre). (a)Minimum of Two operating rooms with 1 operation table each with following capability: equipment for trauma surgery, abdominal surgery, thoracic surgery, arthroscopy (with insufflator) etc., C-Arm, mobile x-ray, ultrasound and x-ray film reading function. (b)One operating room with 1 operation table for specialist surgery: capable of performing maxillo-facial surgery, neurosurgery or ophthalmic surgery and x-ray film reading function. (c)Ability to perform pre-op of patients for surgery, central sterilization with two sterilization units with ability to perform 30 min turnaround of sterilization pack.	Not eligible for NATO common funding. All related costs are the responsibility of the respective nations or agencies since they are directly related to actual treatment other than facility operating costs
3	Intensive Care Unit	MMU	One Intensive Care Unit with 4 Intensive Care beds complete with cardiac and central line monitoring capability and a nurse's station with visibility of all four beds.	Not eligible for NATO common funding as per explanation in line 2.
4	Essential Post-Operative Care	MMU	Recovery Room capability with a minimum of 2 beds with cardiac and central line monitoring capability.	Not eligible for NATO common funding as per explanation in line 2.
5	Blood Replacement Function	MMU / NLD	One blood bank capability with adequate cooling capability and counter space and equipment for routine blood typing and urgent crossmatch.	Not eligible for NATO common funding as per
6	Laboratory Function	MMU	One clinical laboratory which may include but is not limited to: basic blood count, biochemical analysis, blood gas analysis, urine analysis, blood bank and simple rapid immunoassay, microbiology and cold storage. Eye wash station and sink essential.	Not eligible for NATO common funding as per explanation in line 2.

**ANNEX B TO  
AMedP-9.2**

LINE NO	FUNCTIONS	PRESENT SERVICE PROVIDER	REMARKS	1 January - 31 December 20XX Cost €
7	Casualty Staging Unit Function for Aero-Medical Evacuation	MMU	Aero MEDEVAC is the principle means of patient transfer in theatre and aero medical specialists should play a key role in the management of casualties in and out of the Role 3 MTF. The CSU capability provides nursed beds for casualties waiting for intra-theatre or out-of-theatre evacuation.	Not eligible for NATO common funding as per explanation in line 2.
8	X-ray, CT Scanning & Ultrasound	MMU	This function should include the following capabilities: X-ray with area for X-ray film and study examination (reading the films) with appropriate lighting and a telemedicine station for internet access and SECURE external data exchange), CT-scanner, Imaging and diagnostic capability: (one area for routine radiology and one for fluoroscopy, Radiology and Ultrasound), both lead lined. This function will also include ability to develop and store films. The availability of telemedicine may replace the permanent presence of a radiologist.	Not eligible for NATO common funding as per explanation in line 2.
9	Patient Ward Services	MMU	Sufficient capability and capacity to support all clinical activity. A minimum of 12 beds and expansion capacity up to 24 beds.	Not eligible for NATO common funding as per explanation in line 2.
10	Psychiatry or Mental Health Support	MMU	Capable of treating psychological casualties (Post Traumatic Stress Disorder (PTSD)), which may include battle shock and a range of other anxiety and depressive disorders, some of which may be complicated by physical injuries. Capability to treat other acute or chronic psychiatric symptoms.	Not eligible for NATO common funding as per explanation in line 2.
11	Dentistry	MMU	Emergency dental care to include dental trauma/ pain relief therapy (no preventive dentistry or prosthetic treatment capability required, only re-fitting of crowns).	Not eligible for NATO common funding as per explanation in line 2.
12	Emergency Department	MMU	Perform emergency reception, triage and immediate care of casualties in an acute care situation. It includes the provision of cardiac monitoring, enhanced resuscitation, diagnostic, stabilization and follow-on treatment management capabilities.	Not eligible for NATO common funding as per explanation in line 2.
13	Infectious Disease	MMU	Including diagnosis and initial treatment of prevalent diseases e.g. malaria, Leishmaniosis, meningitis, TB. Includes infection control of contagious patients.	Not eligible for NATO common funding as per explanation in line 2.
14	Primary Care Clinic	MMU	Perform integrated, accessible health care services by clinical personnel training for comprehensive first contact and continuity of care. This includes health promotion, disease prevention, patient education and counseling and the diagnosis and treatment of acute and chronic illness for out- patients.	Not eligible for NATO common funding as per explanation in line 2.
15	Sterilization Services	MMU	Sterilization capacity must be sufficient to process all over of all surgical packs and equipment in a 4 hour period. In addition, provision should be made for "Dirty" processing.	Not eligible for NATO common funding as per explanation in line 2.

**ANNEX B TO  
AMedP-9.2**

LINE NO	FUNCTIONS	PRESENT SERVICE PROVIDER	REMARKS	1 January - 31 December 20XX Cost €
16	Physical Therapy	MMU	Limited physical therapy to assist with range in motion and stretching therapy. Assist in out of AOR treatment determination requirements.	Not eligible for NATO common funding as per explanation in line 2.
17	Pharmacy	MMU	Have in-stock a minimum of a 30 day load, ie; enough controlled drugs, supplies and medications for a minimum 30 days. Maintain cold storage refrigeration.  Maintain special storage for narcotics.	Not eligible for NATO common funding as per explanation in line 2.
18	Optometry	MMU	Perform visus control, perimetry (field of vision) and color perception.	Not eligible for NATO common funding as per explanation in line 2.
19	Medical Equipment Maintenance and Repair	MMU	Capable of repairing and maintaining all critical medical equipment in hospital.	€ 0.00
20	Preventive Medicine	MMU	Ensuring safe food and water, vector control and other Preventive medicine functions in accordance with AJMedP-4.	€ 0.00
<b>SUPPORT FUNCTIONS AS OUTLINED IN AJP 4.10(A) &amp; MC 326/2 (Note 2)</b>				
21	Ablution System--staff & patients	KBR /Contractor	Available for patients and personnel. Staff shower and eye wash station near entry area that can be used for decontamination of fuel/chemical spill recommended near emergency entrance.	
22	Staff Accommodation/Billeting	KBR /Contractor	Environmentally controlled accommodation for approximately 100 medical staff, including additional 'on-call' emergency staff, accommodated close to the Role 3 MTF.	Not eligible for NATO common funding as per explanation in line 2.
23	CIS	[LN]	IT connectivity for the command of the Role 3 MTF to include patient tracking facilities. Network system is to be installed in such a way as to allow the dedication of outlets to support ISAF SECRET, Unclass and Centrix network connectivity. Limited to the O&M costs (Note 3).	
24	Potable water supply	KBR /Contractor	Water storage should be capable to supply and maintain operations for 48 hours.	€ 0.00
25	Electricity and backup generator	Contractor	Of sufficient capacity to support operations on 24 hour basis if needed, must have fuel capacity for 16 hours of operation. Limited to the O&M costs (Note 3).	€ 0.00
26	Oxygen Generator	LN/Contractor	Capacity to support 4 lts O2 to four bed and 1lts per hour to 16 beds (32lts/hr), reserve capacity to last 48 hours. Limited to the O&M costs (Note 3).	€ 0.00
27	Sewage & black water system	KBR /Contractor	Provisions must be made to remove sewage from the onsite holding tanks.	€ 0.00
28	Waste disposal to include medical waste (incinerator)	KBR /Contractor	All biomedical hazardous waste, sharp and bio contaminated material needs to be disposed of through incineration because there are no local medical waste companies. Fuel, operation and repair of unit is the responsibility of the medical facility and should be located on the medical facility grounds.	€ 0.00

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<b>LINE NO</b>	<b>FUNCTIONS</b>	<b>PRESENT SERVICE PROVIDER</b>	<b>REMARKS</b>	<b>1 January - 31 December 20XX Cost €</b>
29	Laundry of clinical clothing	KBR /Contractor	Services for cleaning of linen, uniforms and bedding need to be established with local contractor or by providing equipment to staff.	€ 0.00
30	Food & kitchen support for personnel & patients	KBR /Contractor	Arrangement for feeding the staff with the local base food service provider is expected, with additional coordination for the support of inpatients.	Not eligible for NATO common funding as per explanation in line 2.
31	Maintenance of Infrastructure	NSPA/Contractor	Repair and maintenance of Role 3 Facility	€ 0.00
32	Hire of Local Contractors – Interpreters	[LN]	Local Hires Host nation Employment of interpreters in order to facilitate communication with Afghani patients and contractors.	€ 0
33a	Rotation of LN Personnel	[LN]	Deployment of personnel to and from MMU location, two rotations per year	€ 0.00
33b	Rotation of Role 3 Augmentation Personnel	Contributing Nations	Deployment of personnel to and from MMU location, two rotations per year, of personnel designated to augment the Role 3.	
34	Transportation of med eqpt	[LN]	Transportation costs for shipment of medical equipment to MMU location	€ 0.00
<b>TOTAL</b>				<b>€ 0.00</b>

Notes: The capabilities currently provided through the outsourcing should be clearly stated in the "Present Service Provider" column since there is a requirement to get the MC and SRB

- 1 Support functions are being provided through available MMU location APOD RLS contracts that have already been approved as outsourcing.
2. In-theatre infrastructure needed to maintain the minimum military requirements\ is to be funded through the NSIP.

**APPENDIX 4 TO ANNEX B:  
FINANCIAL PROCEDURE FOR [FORCE] RELATED MOU'S RESPECTING  
REIMBURSEMENT TO NATIONS FOR THEATRE LEVEL CAPABILITIES PROVIDED  
TO NATO**

### **Introduction**

1. From time to time, Nations may commit to provide a Theatre capability to *[Force]* for an extended period, to fall under NATO Command and Control. In this case, the decision may be made to consider that Nation eligible for reimbursement of certain categories of costs.
2. Where NATO assumes the obligation for reimbursement to the Nation, a Memorandum of Understanding (MOU) must be agreed and approved. Within that MOU will reside information relating to anticipated costs to be incurred by NATO, either on an annual or once-only basis, or a combination of both.

### **Process**

3. Settlement of previously approved obligations will be undertaken through presentation, by the National MOD, of detailed invoices. The invoice must include, but not be limited to, the following information, so as to ensure prompt processing and payment:
  - a. Full address of supplier (The National MOD);
  - b. Name of bank, bank address, bank account number, Swift and/or IBAN codes;
  - c. Reference: Military Budget Committee decision number;
  - d. Indicate if this is a partial or final invoice; and
  - e. Breakdown of services / goods provided.
4. In addition, sufficient detail on the items to be reimbursed should be included to allow analysis of the eligibility for funding. At least thirty days should be allowed for payment, from the time of receipt of the invoice at the responsible Joint (Task) Force Command.
5. Invoices should be sent to the J8 Finance and Accounting Branch of the responsible Joint (Task) Force Command HQ.
6. The settlement of the invoices will be done as follows:



- a. On confirmation by MBC that the MOU has been approved and, as well, the funds are available:
- (1) The responsible Joint (Task) Force Command will provide a HQ-generated reference number for the MOU and will transmit it to the office designated by the MOD involved. The reference number will cover the total value of all one-time costs, as well as any annual costs applicable to the current year. If any expenditure applicable to future years is anticipated, they will be the subject of future amendments to the PO. This document is purely internal to the responsible Joint (Task) Force Command and provides a reference number to be used by all parties to the MOU so payments may be charged to the correct budget; and
  - (2) Once the PO has been created, a copy will be forwarded to the National Military Representative of the Nation concerned. The Nation will then raise invoice(s) to the responsible Joint (Task) Force Command for the one-time only costs, as well as any annualized costs up to the end of the current year. Thereafter, invoices may be presented on a monthly or quarterly basis for any further on-going operational costs as agreed in the MOU and approved by the Military Budget Committee.
- b. All invoices will be paid through a reduction of nation's annual contribution to the AOM budget by the amount authorized.

7. Should any questions arise with respect to the payment process, the responsible Joint (Task) Force Command Point of Contact (POC) is:

*[Insert contact information here]*

**ANNEX C: AIDE MEMOIRE: PLANNING CONSIDERATIONS FOR THE LEAD NATION WHEN ESTABLISHING A MULTINATIONAL MEDICAL UNIT**

**Intent: This Aide-Memoire has been developed to identify planning considerations which should be taken into account by the Lead Nation responsible for the establishment of a Multinational Medical Unit (MMU). This Aide Memoire has been developed based on previous experiences / Lessons Learned and can provide a Lead Nation with a start point from which to manage the differing requirements and contributions of Participating nations. As NATO missions will differ, not all considerations will apply to each mission.**

Serial	Action by:	Description	Secondary Description	Considerations	Related Publications
1	<b>MMMSG</b>	Mission		Define the mission to be accomplished.	
2		Direction	Required services and capabilities	The MMMSG should direct what services, capabilities and capacities will be required.	<i>AJMedP-9 Multinational Health Service</i>
3			Early entry forces (advance)	What capabilities will be required to support the early entry forces?	
4			Entitlement to care.	Who will be eligible for care at the MMU?	
5				Will the MMU be static, or will there be a requirement for mobility?	
6		Designation of Lead Nation		If the Lead Nation status will rotate, the rotation schedule should be determined as early as possible.	
7		TO&E and contributions		What is the required manpower to support the MMU?	
8				What is the manpower required to support the early entry forces?	
9				When is the anticipated in-flow of troops that will require support?	
10				What nations will contribute HSS and support personnel (broken down by rank, profession, gender...)?	
11		MOU		Develop the MOU for approval by participants.	MMU MOU template

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12		National caveats		Are there any national caveats that restrict full employment of any personnel? Are there national liability concerns for treating different categories of patients, e.g., military, civilian, NGOs?	
13		Geneva Conventions considerations		What is the policy for use of Red Cross? Are there any other implications pertaining to the Geneva Conventions?	
14		Mentoring of HN military and civilian HSS pers		Will there be any requirement to mentor HN Military or civilian personnel, at the MMU, or at other locations? – if so, additional personnel should be added to the TO&E, assigned to a dedicated task.	
15		Medical Civil Action Projects (MEDCAPs)		Will there be any MEDCAP activities that the MMU will be required to support? What are contributing nations' policies towards using their personnel for MEDCAPs?	
16	<b>Regional Command or Operational HQ</b>	Designation of Regional/Command/Force Medical Advisor/Director			
17		MED ROEs	Medical Rules of Engagement	Do they cover all coalition forces including host nation personnel, as well as detainees/POWs and any civilians?	
18		Holding policies		What is the holding policy for NATO and coalition forces, detainees, local nationals and displaced persons?	
19		Humanitarian Affairs		What HA activities will be carried out in the AOR, and will the MMU Participate?	2227, AMedP-15
20		Casualty Evacuation Plan		What is the plan for evacuation of casualties - NATO and coalition forces, detainees, local nationals and displaced persons?	2546, AMedP-2
21	<b>Lead Nation and Troop Contributing Nations</b>	Force Generation		Pre-deployment individual training – IAW national policies. What training will be accomplished, both military and professional skills and re-certifications?	2122, 2235, 2249, 2544, AMedP-22

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22				Pre-deployment collective training. Will collective training for all personnel be accomplished at one location, or will each nation conduct the necessary collective training independently. If collective training can be conducted in one location, it will allow for enhanced team building and comradeship, improved understanding of national differences and similarities, and improved reaction times in the initial phases of MMU stand-up.	
24			Medical and Dental Fitness	Are all personnel deploying medically and dentally fit?	2466, AmedP-4.4
25			Evaluation of MMU and components	STANAG 2560 and AMedP-27 should be consulted to ensure appropriate evaluation is conducted.	2560, AMedP-27
26		National level Command and Control	C2 – National and MMU	Have all National Contingent Commanders been designated and linkages made between those leaders and the command team of the LN.	
27	<b>Lead Nation Command Team</b>	Doctrinal Review against proposed mission		Does current doctrine address the mission requirements? Are there any gaps which must be addressed?	National Doctrine, AJP-4.10(B)
28		Designation of Facility Medical Director		Designating the Commanding Officer and senior command team as early as possible will improve coordination and ease the transition to full operational capacity.	
29		Mission Planning		Thorough operational mission planning will identify most gaps and increase the likelihood of a smooth deployment and establishment of the MMU.	2542, AMedP-1
30		Medical Recce		Will there be representation of MMU leadership on the recce?	
31			Med Int	What intelligence and information is available on civilian health facilities in the MMU region?	

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32		SOPs		Development of facility SOPs and promulgation of those before collective training will increase staff familiarity with clinical and administrative activities.	
33		MASCAL plan		A facility MASCAL plan should be developed in conjunction with the force and base plans as it may be required before the facility is fully operational.	
34		Casualty estimates (in conjunction with G/J3, 5, 2 and 1 pers)		Have reasonable casualty estimates been determined? Are there sufficient resources integral to the MMU to provide the appropriate standard of care?	
35		Threat assessment		What threats might the facility be exposed to (CBRN, direct or indirect fire, adverse weather, environmental health concerns...)? Are there sufficient resources to identify and deal with these threats in a timely fashion? (Resilience plan)	2478
36		Requirement for Mental Health outreach services		Will mental health personnel be required to work outside the facility? Would outreach be required in normal conditions, and if not, in a disaster situation would outreach be necessary – consider enhanced staff if likelihood is high? Other peripatetic services eg physiotherapy.	
37		National and NATO Health surveillance requirements		What health surveillance system will be used? Is there an IT or comms requirement attached, or dedicated staff/specific training?	2277
38		Determine Facility lay down	Physical space requirement	Identify space requirements, possible sites for facility lay-down, and what services will be required that do not exist. See infrastructure section.	

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39		Patient Evacuation Plan		What is the plan to evacuate patients – Strategic patient evacuation is a national responsibility, and nations should consider consolidating capabilities to conserve resources. How will host nation forces and civilians be handled?	
40		Back-up facility (business continuity / resilience plan)		Even if a theatre reserve facility exists, a plan for a backup facility should be developed to ensure that a disaster (man-made or natural) does not compromise the operation of the facility.	
41		Public Affairs/Media plan		Does the MMU have a public affairs or media plan? Who will be designated to speak to the media for the MMU and is special training be required?	
		<b>Personnel</b>			
42		Lodging		Where will MMU personnel be lodged? Are the facilities adequately quiet to allow shift workers to have uninterrupted sleep? Are there adequate beds in the facility or RSOM facilities to deal with transition periods? Are there adequate ablution facilities to maintain an acceptable standard of hygiene?	
43		Feeding		Is there a messing facility in relatively close proximity in the event of an emergency recall? Are vehicles required to ferry personnel to/from meals, if so, adequate vehicle support will be required?	
44		Recreation facility access		Are there sufficient recreation facilities available? Consider all participating nations.	
45		Movement to/from theatre	Reception, Staging, Onward Movement of HSS personnel	What is the RSOM plan – does it allow for smooth movement in/out of theatre? Is the system reliable – if not in/outflow might be interrupted. Consider all participating nations. Adequate time for handover between participants?	

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46		Mail		Are there postal facilities which will allow mail to be sent and received? Consider all participating nations.	
47		Mid-tour Leave requirements		Will staff be eligible for leave part way through their tour? Consider all participating nations and deconflict. Staff augmentation may be required to back-fill those personnel on leave.	
48		Working limitations such as national caveats,		Are there any national agreements/caveats or conditions of employment for Participating Nations that may limit their employment (i.e. max hours worked per day, working conditions)?	
49		Locally engaged staff	Cleaners	Is the facility cleaned by locally engaged persons? Who is responsible for the contract, and who sets the conditions/standards?	
50		Interpreters	Local Nationals or from a Contributing Nation	24/7 coverage will be required. Are there adequate interpreters available to cover peak periods? Are all languages and dialects covered?	
51		Spiritual support to staff		Is there adequate spiritual support for staff? Will any special considerations be required to allow staff to attend religious services?	
52		Ethical Frameworks		Is there an ethical framework to deal with ethical dilemmas, and adequate resources to support the staff?	
53		Cultural considerations		Are there any staff members that require special considerations related to their religion, culture or language?	
54		Language		What is the working language in the MMU? Are their national requirements regarding language of documentation?	
		<b>Logistics</b>			2128 2178

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55		Medical oxygen generation--standards		Will the facility possess the equipment to generate medical standard oxygen? Will the facility have oxygen piped to all patient care areas, or will compressed gas cylinders be used? Will the facility supply any other facilities or units? Will the facility use 99,5% oxygen or 93% oxygen?	2121, 2558
56		Medical Equipment	Repair and maintenance	Will medical equipment be repaired locally or replaced? Is there adequate qualified staff to conduct the repairs? Will there be a requirement for those technicians to service any other equipment in theatre?	2040
57			Spare equipment	Are there adequate spares to replace defective equipment until it is repaired, or to deal with peak periods where additional equipment may be required? In extreme environments (i.e. dust, heat) consider increasing spares.	
58			Spare parts	Does the repair department have adequate spares to conduct repairs, without having to order parts? In extreme environments (i.e. dust, heat) consider increasing spares.	
59			Tools and repair equipment	Is there adequate repair equipment to repair/test the equipment to ensure it meets industry standards?	
60		Medical Stores		What medical supplies will be held in theatre? How many DOS will be held? Will resupply come from in-theatre, from an agency such as NSPA, from the Lead Nation, or a combination of the above?	2060
61			Cold chain	Is there proper cold chain management of temperature sensitive drugs, supplies, blood and blood products?	
62			Blood and Blood Products	What is the blood and blood product supply and management plan?	2939, 2408



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63			Replacement stores	Replacement equipment such as stretchers and blankets. The MMU must have a sufficient supply of items such as stretchers and blankets to restock ambulances and replace any damaged equipment, or provide additional stores in the event of a MASCAL.	2040
64		General Stores		What general stores must be held to ensure smooth operation of the MMU? Will they be held with medical supplies, or in a separate general stores area – if so a dedicated staff will be required?	
65		Mortuary Services		Who will provide mortuary services and where will they be located?	2132
66		Vehicles	Ambulances	What ambulances will be required? Will the ambulances be soft skinned and/or armored? Access & egress?	2342, 2872
67			Logistical support vehicles	Are there adequate logistical support vehicles to support the daily operation of the MMU?	
68			Maintenance	Who will provide vehicle maintenance above the driver maintenance level?	
69			Fuel and oil	Where will the vehicles procure their fuel and oil?	
70		Force Protection/Security	Threats	Does the MMU possess adequate equipment to deal with threats such as CBRN threats?	
71			Physical security plan	What is the physical security plan for the facility? Are the entrances and exits easily secured? Is there a separate secure area to hold detainees?	
72			Screening of local patients and escort	What is the plan for screening local patients and their escorts? Consider both physical screening as well as determination of their threat status (ties to insurgent groups).	

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73			Detainee/POW handling and security	What is the detainee handling plan? Who will provide the guard? Is there a secure place to hold detainees/POW, and is there an overflow plan to handle additional detainees/POWs? What are the discharge criteria to be used for determination of handover to the detaining nation?	
74			Protection from direct/indirect fire	Is there adequate protection of staff and patients from direct and indirect fire?	
75			Capacity for mass immunizations	Does the MMU possess adequate supplies, staff and space to conduct a mass vaccination program if required?	
76		Trauma Registry		What Trauma Registry will used? Will there be a requirement for a dedicated staff, special equipment and telecommunications links, or space requirements?	
77		Strat Evac		Each TCN, agency and contractor is required to make arrangements to provide or ensure contracts in place to evacuate patients back to their home nations. Are these contracts in place, and what is the contact information if these services are required? Nations should consider mutual support agreements to share resources.	2132, 3204
78			Support to strategic air evacuation teams	What specific support requirements will be required to support the strategic evacuation teams?	
79		IM/IT	Telecomm Equipment	What telephone links will be required to communicate with home nation, as well as other partners, including local facilities? Will secure telephone systems be required?	
80			National links (rear links)	What national links will be required to transmit data signals – i.e. computer, telemedicine, teleradiology?	
81			Local connections	What systems will be required to communicate locally? If local internet provider is used, how secure is it?	

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82			NATO Systems – telephone and computer	Will a NATO (Classified) system form the main IT system? If the majority of the MMU functions on a national system, where will NATO terminals be required?	
83			Inter-operability with other systems – data interchange	Are your IT systems inter-operable with other systems? Can information be transferred with disks or memory sticks?	2543
84			Pagers/Recall	What system will be used to recall essential personnel?	
85			Computers/printers/servers...	Are there adequate servers, Work stations and computer peripherals to manage operations and provide administration?	
86			Telemedicine (Teleconsulting)	Will telemedicine services be available? Will special equipment or support be required?	2517
87			Teleradiology	Will teleradiology services be available? Will special equipment or support be required? Will the system be interoperable with other partner health facilities?	
88			Patient regulating (i.e. TRAC2ES)	What patient regulating system will be used? Is it interoperable with national systems?	
89			Disease Surveillance	What disease surveillance system will be used? Is it interoperable with national systems?	2050, 2535, AMedP-21
90			Lessons Learned	Will the MMU use an electronic LL database or have linkages with JALLC?	
91			EPINATO	Will EPINATO be used?	
		<b>Administration</b>			
92		Initiating Agreements with HN and TCNs		Does an IA exist with the Host Nation? What implications does it have on delivery of care to local nationals or use of local services? How will billing for services rendered to TCN be conducted?	

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93		Medical Records	Electronic – accessible to TCNs?	How will medical records be stored (security and confidentiality)? Will an electronic system be used – if so, is the system interoperable with other nations? If the system is not interoperable, what is the plan to transfer patient records?	2347, 2348
94			Disposal of records post deployment	What is the policy to dispose of health records of patients from other coalition nations? For local nationals, detainees/POWs, or displaced persons? What are national requirements for retention of clinical records?	
95		Admin Sp	National level support to staff	What is the admin support plan for staff of the lead nation? How will participating nation's staff be supported administratively?	
96		Admin Sp to patient	National level support to patients	How will patients be supported administratively?	
97		Credentialing/privileging		How will credentialing/privileging requirements be administered?	
98		Hostelling of Local National (LN) escorts		Depends on culture, some In-patients (women, children) may require escorts to remain with them while they are hospitalized. If so, what support and security monitoring arrangements are required to accommodate them	
99		Finance	NATO Common Funding MOU	Does NATO Common Funding apply to the MMU? If so, has the MOU been initiated?	
100			Auditing	If NATO Common Funding is applicable, what information will SHAPE J8 require in the event an audit is performed?	
101			Petty Cash Fund	A petty cash fund to support local nationals (travel) is recommended. Depends on distances and transportation services, moving local nationals back to their villages following treatment may require the MMU to fund that transportation.	

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102			Billing for services provided	The Lead Nation can bill nations and contractors for patient services rendered, IAW the MOU. If billing is conducted, a billing mechanism to bill contractors or other nations for health care services is required. This may also require additional staff in the MMU unless the national contingent J8 will perform that function.	
103		Reports	Reporting requirements	What reports will be required (i.e.: MEDSITREPS, MEDASSESSREPS) for higher HQs and national chains. What formats will be used, and how will the information be sent?	
		<b>Liaison</b>			
104		Chain of command – Theatre and National		What linkages exist for communicating with the theatre and national chain of command? How will the MMU communicate with the CoC of other TCNs regarding their casualties?	
105		Host Nation		What linkages exist with Host Nation civilian and military health services? What are the names and contact numbers?	
106		Supporting agencies		What linkages exist with supporting or supported agencies: Government Organizations International Government Organizations and Non-Government Organizations?	
107		Supporting medical facilities		What linkages exist with supporting and supported medical facilities?	
108		Military police		Is there liaison between the Military police organization and the MMU?	
109		Logistics support organizations		Is there liaison between the Logistic Support Organizations and the MMU?	
110		Food Services		Is there liaison between the food service organizations and the MMU?	
111		Spiritual/religious support		Is there liaison between the Host Nation spiritual and religious communities and the MMU?	

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		<b>Staff Education/Mentoring of HN Med Pers</b>			
112			Grand Rounds	Will the MMU conduct grand rounds? Who can attend? Will it be open to HN medical civilian and military pers?	
113			Availability of medical texts and references	What printed and electronic reference texts and resources will be available to staff?	
114			Support to HN Med Pers	Will there be any mentoring activities performed by the MMU to support the development of HN medical personnel? Will additional resources be required to support this activity?	
		<b>Infrastructure</b>			
115		Facility – Maintenance agreements	NSPA or LN national support	What maintenance agreements are in place, or will be negotiated to maintain the infrastructure of the MMU?	
116		Potable Water		Is there adequate potable water to service the MMU?	2136, AMedP-18
117		Electrical	Power (voltage/amperage)	Is there adequate electrical power to supply the facility? What is the voltage and amperage of the facility and is it sufficient to meet the electrical requirements?	
118		Communication capability / capacity	Bandwidth	Is there adequate capacity to permit transmission of images such as CT images?	
119			Backup power	Is back up power available in the event of a primary generator failure? Are there any services that are not supplied by a back-up generator?	
120		Patient feeding		How will food be provided to patients? Will it be prepared on site, or at another location? How will it be stored and transported? Can it be adapted for patient clinical and religious requirements?	
121		Toileting and bathing facilities		Are there adequate toilets and bathing facilities for patients and staff incl. separate secure area for detainees etc? How will infectious patients be managed?	

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122		Climate control		Is there adequate ventilation and temperature control to keep staff and patients comfortable?	
123		Adherence to fire codes		Is the MMU compliant with fire codes applicable to Lead Nation? (i.e.: smoke detectors, fire extinguishers)	
124		Refrigeration		Is there adequate refrigeration available for medical –specific use such as medications and blood banking, along with connection to backup power sources?	
125		Weapons storage		How will staff/patient weapons be securely stored?	
126		Expansion capability		Is there space and equipment / personnel? To expand the MMU if an increase in beds is required, or services added?	
127		Suction		Is suction available in all patient care areas? How is the waste disposed of?	
128		Sterilization		Is there adequate capacity to sterilize appropriate equipment, on a routine basis? Is there a requirement to support other facilities?	290 6
129		Proximity to helicopter landing zone		Where is the helicopter LZ located? Is there a clear path to the emergency entrance?	
130		Appropriate traffic pattern		Is there an appropriate traffic pattern to/from the emergency entrance to allow safe loading and unloading of patients?	
131		Adequate parking areas		Is there adequate parking space for visitors?	
132		Storage capability for medical supplies		Is there adequate storage for medical supplies? Is it secure and is there space for expansion if required?	
133		Blood and blood product storage capability		Where will these products come from? Is there adequate storage for blood and blood products? Are there alarms on the storage units that are audible in areas staffed 24/7, or remotely wired into the duty center?	

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134		Medical gas storage		Is the storage area for medical gasses secure, and protected from direct and indirect fire?	
135		Infection control		Does the MMU have isolation rooms? Is there an infection control plan?	
		<b>Patient Services</b>			
136	<b>Medical Director and Staff</b>	Standards of Care		Standards of care should be established early and agreed upon prior to deployment by all participating nations.	
137			Disposition of patient following treatment	How will discharged patients be handled?	2061
138		Dental Care			2453, 2465, 2464
139		Pharmaceutical Care			
140		Preventative Medicine	e.g., food/potable water inspection	Who will they support and what services will be offered?	2048
141		Veterinary Services		Will veterinary services be provided in proximity to the MMU?	2534, 2538
		<b>Environment</b>			
142		Biomedical Hazard Waste disposal		What is the biomedical hazard holding and disposal plan? The plan must include adequate supplies and equipment to properly contain and handle the waste.	
143		Disposal of medications		What is the disposal plan for medications that have expired? Are special procedures required for disposal of narcotics and other controlled substances?	
144				How will the non-clinical waste be disposed? How will it be stored between pick-ups?	
145		Environmental concerns		Are there any other environmental concerns that could endanger patients or staff?	
		<b>Force Health Protection</b>			
146				What FHP measures/recommendations are in place?	



**ANNEX D: EXAMPLES OF NON CLINICAL R3 MMU STANDARD OPERATING PROCEDURES**

**Note:** These USOPs are intended to serve as a guideline to provide a start point for the Lead Nation of a MMU and will require adaptation to meet operation – specific requirements. USOPs with a clinical focus have been removed as current medical practices will change over time and the Lead Nations will be responsible to provide clinical USOPs based on the prevailing best clinical practices.

APPENDIX	NAMES	NUMBER
1	MEDEVAC REQUEST	1100-1
2	EMERGENCY RESPONSE ON BASE	1100-2
3	CASUALTIES BROUGHT TO BASE MAIN GATE	1100-3
4	PATIENT ADMISSIONS AND DISCHARGES	1100-4
5	FACILITY RECALL PROCEDURES	1100-5
6	FACILITY SECURITY PROTOCOLS – LN PERSONS	1100-6
7	CRITICAL INFORMATION REQUIREMENTS	1100-7
8	DUTY OFFICER ROUTINE TACTICAL OPERATION CENTRE	1100-8
9	VISITORS FOR PATIENTS	1100-9
10	DUTY RUNNER / DRIVER	1100-10
11	EVACUATION PROCEDURES	1100-11
12	CLEANING PROCEDURE FOR SPACES CONTAMINATED WITH HUMAN BIOLOGICAL WASTE	1400-1
13	HANDLING MERCURY SPILLS	1400-2
14	BIOMEDICAL WASTE DISPOSAL	1400-3
15	RABIES AND ANIMAL BITE MANAGEMENT	1400-4
16	EMERGENCY RECALL DRIVING PROCEDURES	1600-1
17	INTERPRETERS	1900-1
18	DETAINEE OPERATIONS	2000-1
19	DENTAL SECTION	2100-1
20	PHYSIOTHERAPY DEPARTMENT SERVICES	2400-1
21	ALTERNATE SURGICAL SITE	2700-1
22	ALTERNATE INTENSIVE CARE UNIT / INTENSIVE CARE WARD	2700-2
23	BIOHAZARD WASTE DISPOSAL (IN PATIENT SERVICES)	2800-1
24	DETAINEE CARE	2800-2
25	IN PATIENT SERVICES (IPS) VISITORS	2800-3
26	PROCEDURES DURING INDIRECT FIRE (ROCKET ATTACK)	2800-4

**ANNEX D TO  
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27	TRAUMA TEAM ACTIVATION	2800-5
28	VOLUNTEER SERVICES DUTIES AND RESPONSIBILITIES	2800-6
29	WARDMASTER 2 I/C DUTIES AND RESPONSIBILITIES	2800-7
30	CONDUCTING 9-LINERS ARRIVING AT THE MMF	2900-1
31	QUALITY ASSURANCE	3000-1
32	AUTHORIZED IMAGERY WITHIN MMU	7500-1

**APPENDIX 1 TO ANNEX D  
USOP 1100-1: MEDEVAC REQUEST**

1. The purpose of this FSOP is to outline the procedures in the event of a MEDEVAC request.
2. Depicted below is the sequence of events, which occur once the MMU Tactical Operations Centre (TOC) receives a MEDEVAC Request.
  - a. Receive MEDEVAC Request. Once RC Med Ops recommends the Multinational Medical Facility (MMF) receive the patient(s), the TOC Duty Officer (DO) immediately records the info and conducts a time appreciation to determine an estimated time of arrival for MEDEVAC emergency patients to the facility;
  - b. Conduct MEDEVAC Request orders. The TOC DO pages the Duty MO, Evac IC, and Charge Nurse to report to the TOC for 9-line orders. The DO disseminates the MEDEVAC Request information to the above mentioned staff and together conduct battle procedure to determine, which clinical positions need to be present when the emergency patients arrive. The Duty MO will decide if a complete recall of staff is required (for multiple casualties) or if only specific teams are necessary;
  - c. Contact required clinical staff. The TOC DO will page or call all staff requested by the duty MO during MEDEVAC Request orders. The DO will record what time the staff was paged and be prepared to dispatch a runner if the member has not checked into the TOC after 10 mins. Activate the camp recall system if required; and
  - d. Patient arrives. Once the patient has arrived at the MMU, back brief the event to RC Med Ops.

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**APPENDIX 2 TO ANNEX D: USOP 1100-2: EMERGENCY RESPONSE ON BASE**

1. The purpose of this USOP is to outline those procedures required to ensure an appropriate response in case of on-camp emergency or in flight emergencies requiring the services of an ambulance.
2. The MMU is mandated to provide emergency responses to incidents on the base. Requests for emergency response can be made by dialing *[to be determined]*, which automatically connects the caller to the Base Operations Cell. The TOC DO could expect some emergency calls, from time to time, as not all callers know to dial *[to be determined]*.
3. When a call is made to the Base Operations Cell requesting an ambulance in response to an Emergency within the base:

Base Operations Cell:

- a. Will gather as much information as possible on Amb request form (Annex A) to ensure respondents have all required information to properly answer request, and instruct caller to remain on-site with Casualty and wait for the ambulance to arrive;
- b. Call the MMU and relay information and request that an Amb be dispatched; and
- c. Will follow up with TOC DO for a SITREP once the patient has arrived at Role 3.

TOC DO:

- a. Will monitor ambulance on the radio at all times;
- b. In the case of a *[to be determined]* call, will inform and pass all relevant information to Duty Doctor and Charge Nurse; and
- c. Will continue to monitor net and pass any updates as necessary.

4. MMU will send an ambulance to casualty point, and return with patients to either Primary Care or the Trauma Bay, depending on nature of injuries. They will remain in radio contact at all times and will relay patient information back to TOC DO, who will then relay this back to Duty Doc. Duty Doctor will determine where the patient will go; Trauma Bay or Primary Care.

5. In the event that a call comes directly to the TOC DO, he/she will pass all relevant information to the ambulance team who will dispatch an ambulance. The DO will then inform the Duty Doctor and Charge nurse and pass on all relevant information.

6. Should casualty be admitted at MMF, admission is to be reported as per FSOP 1100-6 PATIENT ADMISSIONS AND DISCHARGES.  
TOC DO USOP – Emergency Response on Camp, see following page

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**TOC DO USOP – Emergency Response on Camp  
AMBULANCE REQUEST**

DATE: \_\_\_\_\_

TIME AMB SENT: \_\_\_\_\_

TIME OF CALL: \_\_\_\_\_

1	LOCATION OF INCIDENT:	
2	NUMBER OF CASUALTIES (include nationality if possible)	
3	INJURY / ILLNESS	<b>NATURE OF INJURIES / ILLNESS</b>
4	LEVEL OF CONSCIOUSNESS	CONSCIOUS/ UNCONSCIOUS
5	FIRST AID ADMINISTERED	Y / N
6	RV POINT	
7	POC	
8	***INSTRUCT CALLER TO KEEP CASUALTY ON SITE AND WAIT FOR AMBULANCE***	
<b>SPECIAL INSTRUCTIONS/REQUIREMENTS &amp; ADDITIONAL INFO</b>		

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<p><b>APPENDIX 3 TO ANNEX D USOP 1100-3: CASUALTIES BROUGHT TO BASE MAIN GATE</b></p>
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Reference: Force Medical Directors Rules of Eligibility

1. This USOP outlines the Emergency procedures when a casualty is brought to the Base Main gate for treatment at the MMF.
2. When a casualty is brought to the gate, the Gate guards will call the MMF Tactical Operations Centre (TOC) Duty Officer (DO), who will in turn call the Duty Medical Officer. The DO will brief the Duty MO on all pertinent details. The Duty MO will make the determination (unless prior consent was given) on whether or not the casualty (ies) will be accepted at the MMF for care. If there is not enough information the Duty MO may dispatch an ambulance with a triage team to the gate who will relay more information back to the TOC.
3. IAW with Ref, Local Nationals (LNs) severely ill or injured for reasons unrelated to the conflict may only receive treatment in a Coalition Force (CF) Medical Treatment Facility (MMF) if the following criteria are met:
  - a. The severity of the injuries meets Life/Limb/Eye sight (LLE) requirements;
  - b. Availability of transport;
  - c. Ability of receiving MMU to provide care to LN. This is based on our bed state; or
  - d. A higher authority has approved for the casualty to receive treatment at MMU (e.g. TF Comd).
4. If the Duty MO has established that the casualty is eligible, TOC DO will call the Regional Med Ops to ask for final approval to bring the patient to the MMU.
5. Should injured LN not meet any of the above criteria, casualties are then to be referred to local hospital.

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<p style="text-align: center;"><b>APPENDIX 4 TO ANNEX D USOP 1100-4: PATIENT ADMISSIONS AND DISCHARGES</b></p>
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1. The following USOP outlines the procedures on admissions and discharges patients.
2. Upon admission and discharge of a patient at the MMU, the TOC DO is to register patient information:
  - a. In the Admission and Discharge Book;
  - b. In the Daily Situation Report; and
  - c. Other requirements as required by Regional Command Med Ops or national bodies.
3. Specific discharge instructions:
  - a. Coalition Soldiers: Contact respective point of contact or Role 1 to facilitate transport;
  - b. HN Soldiers: For patient transfer, contact HN Medical Liaison Officer and ask them to send an Ambulance to MMF for a patient transfer.
  - c. Local Nationals:
    - (1) If the patient is ready to be transported to the local hospital, ask interpreters to contact the Hospital and ask them to send an ambulance to the Base Main Gate. Primary Care will facilitate transport to the Main Gate; and
    - (2) If the patient is ready to be discharged home, if national protocols allow, taxi fare can be provided. Ask the interpreter to estimate an appropriate amount. TOC DO will fill out required form and have Primary Care transport patient to the Main Gate for connection with a taxi.
4. For SOF patients, national practices will vary on the method of reporting their casualties.

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<p style="text-align: center;"><b>APPENDIX 5 TO ANNEX D USOP 1100-5: FACILITY RECALL PROCEDURES</b></p>
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1. This USOP outlines the procedures for the recall of MMU personnel.
2. Decision authority to recall MMU staff is held by the facility specialists, duty Medical Officer, and charge nurse. In all cases, if members do not respond to their page after 20 mins, a runner will be sent.
3. Certain departments have included the circumstances for their staff recall and should be abided to as much as operationally possible.

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<p style="text-align: center;"><b>APPENDIX 6 TO ANNEX D</b> <b>USOP 1100-6: FACILITY SECURITY PROTOCOLS – LOCAL NATIONAL PERSONS</b></p>
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1. This USOP outlines the procedures to follow in order to assure security upon the admission of a local national patient under the age of 18, and accompanied by a guardian at the MMU.

**Note:** *Cultural norms may require that a female is accompanied by a male escort, who is required to stay in proximity while she is away from her family.*

2. When a local national under the age of 18 is admitted to MMU, it is mandatory for them be accompanied by a guardian. It is also necessary to ensure security on the guardian. A guard should be present 24/7 to ensure local national personnel do not leave the MMF, or go into restricted areas.

3. A 24-hour shift of two guards is assigned daily to a unit by the Camp Sergeant-Major. In most cases, only one guard is required. The ward master, charge nurse and TOC Duty Officer assess the need for the second guard.

4. The Ward Master is responsible to brief the guard(s) at the start of each shift.

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Effective:

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<p style="text-align: center;"><b>APPENDIX 7 TO ANNEX D USOP 1100-7: CRITICAL INFORMATION REQUIREMENTS</b></p>
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1. As in all unit command posts, the Duty Officer must ensure that information gets passed to the applicable department or sub-section in a timely manner. However, it is imperative that particular information gets to certain positions in an emergent fashion. It is for these reasons that the MMU Critical Information Requirements (CIR) exist.

2. Attached at Tab A, are the situations in which the MMU CO must be contacted immediately. Many issues may arise which are important but not specifically stated in the CCIR. In such scenarios, contact the MMU Deputy Commanding Officer who will determine if the Commanding Officer needs to be briefed immediately or if it can wait to the morning TOC Update Brief.

OPI: Adjt  
Effective:  
Revised:

**Appendix 7 Tab A - Commander's Critical Information Requirements**

Duty staff must immediately notify the Commanding Officer if the following occurs:

1. Death or serious injury to a member of the MMU.
2. Loss of critical facility capability (Blood, DI, Surgical, Bed status at RED, etc.).
3. Death of a Coalition Soldier in the facility.
4. VIP visitor to the facility.
5. Potential incident, MMU personnel (i.e. Did not follow LOAC rules) MASCAL.
6. For significant incidents, other than those noted above, the Deputy Commanding Officer will be notified for determination if the Commanding Officer needs to be advised.

**APPENDIX 8 TO ANNEX D**  
**USOP 1100-8: DUTY OFFICER ROUTINE TACTICAL OPERATION CENTRE (TOC)**

1. This USOP outlines the Tactical Operations Centre (TOC) Duty Officer's (DO) daily routine and battle rhythm.
2. Shifts. The MMU TOC is to be manned 24/7 with 3 Duty Officers on 12 hr rotation, as depicted in sub para a thru b. The oncoming DO is to report to the TOC at least 15 minutes prior to the start of his shift to ensure adequate handover time from the previous DO:
  - a. Day shift. 0630 hours to 1830 hours;
  - b. Night shift. 1830 hours to 0630 hours.
3. Shift Handover. Shift Handover is to include the fol:
  - a. Pending 9-liners;
  - b. Pending Patient Transfers;
  - c. Pending admission and/discharged in ward/trauma bay;
  - d. Log-book's follow-up points;
  - e. Review of MMU and battle space operations since the member was last on shift; and
  - f. Ensure that Safe's keys are in the first drawer, that the Crypto Log is signed, and that the Command Post is clean for the oncoming shift.
4. Reports & Returns. The TOC has various reports and returns to produce on a daily basis, while others are done after specific events. Force SOPs details the Medical Reports & Returns. The main reports are listed and then described in detail below:
  - a. Daily Situation Report (DSR): The Daily Situation Report (DSR) is to be sent three time a day at 0600, 1800 and 0001. It reports on the current bed state of the Role 3. The report is to be sent via secure e-mail to: (add addresses specific to your mission) Tab B displays the format for a MEDINCREP;
  - b. Regional Command Bed state: Once Med Ops has had a chance to compile each MMF's bed state, they will send it out twice daily, usually 0645 in the morning and 1845 in the evening;
  - c. Tactical Operation Centre Update Brief (TUB): The MMU Tactical Operational Centre Update Brief occurs daily at 0845 at the TOC.

In order to give situational awareness to Key MMF Staff on Hospital and Battle space operations for the last 24 hours and any known hospital or battle space operations in the next 24 hours. The following pers attend the TUB, but not limited to them;

- (1) Commanding Officer / Task Force Surge;
  - (2) Regimental Sergeant Major;
  - (3) Deputy Commanding Officer;
  - (4) Officer Commanding MMU;
  - (5) Company Sergeant Major MMU; and
  - (6) Adjutant.
- d. Medical Incident Report (MEDINCREP): The Medical incident Report (MEDINCREP) is filled in order to report significant medical incidents, which occur at the MMU as per FORCE SOPs. The fool medical incidents constitute the necessity to send a MEDINCREP;
- (1) Deaths in a MMU or during patient transport;
  - (2) Death or serious injury to a coalition force member, local national in a MMU, or during a MEDEVAC;
  - (3) Outbreak of infectious or communicable diseases involving > 12 personnel;
  - (4) Impact on medical capabilities including loss of an aero medical capability;
  - (5) Suicide or self-harm;
  - (6) All MASCAL incidents across theatre;
  - (7) Loss of a surgeon/ medical officer/ dental officer/ physician's assistant;
  - (8) Confirmed cases of malaria and pandemic influenza strain, such as H1N1;  
  
Declaration of Bed State Black by a R2/R3 facility;
  - (9) CBRN;
  - (10) Serious incident involving medical personnel;

- (11) Offensive actions against a R2/R3 facility; and
- (12) Admission to a MMU of an officer of OF4 or above.

**Note:** *The MEDINCREP report is to be sent via secure e-mail to the to: (add addresses specific to your mission). Tab B displays the format for a MEDINCREP; and*

- e. Admission & Discharge Log: The Admission and Discharge log must be completed after each patient admission or discharge to the MMU. For further explanation on the admission and discharge processes consult USOP 15001.
- 5. Emergencies on Base. Standby to respond to emergency calls on base.
  - 6. Casualties brought to the Main Gate. Standby to action requests of casualties brought to the Main Gate.
  - 7. In-flight or ground emergencies. Standby to respond to requests related to in-flight emergencies.
  - 8. Update and maintain phone lists and recall lists as necessary.  
Daily Situation Report (DSR), see Tab A  
Medical Incident Report (MEDINCREP), see Tab B

**Tab A - Daily Situation Report (DSR)**

1. The Daily Situation Report (DSR) is produced by the TOC Duty Officer. It is to be sent via secure email to addresses as directed by the Force Medical staff, three time a day, at 0600, 1800 and 0001.

Example:

**TAB 1**

Daily Regional Report for RC Date: 15.03.07		BED STATUS SUMMARY								
		Beds		Patients						
		# of Beds	% Occ	Total Occ	EVENT			DNBI		
					CF	HNSF	LN	CF	HNSF	LN
<b>Non-ICU</b>										
MMF R3	12	0%	0							
COUNTRY R2	24	0%	0							
COUNTRY R2	14	0%	0							
COUNTRY R2	6	0%	0							
COUNTRY R2										
<b>Non ICU Total</b>	<b>56</b>	<b>0%</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>ICU</b>										
MMF R3	4	0%	0							
COUNTRY R2	4	0%	0							
COUNTRY R2	2	0%	0							
COUNTRY R2	2	0%	0							
COUNTRY R2	3	0%	0							
<b>ICU Total</b>	<b>15</b>	<b>0%</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total Patient</b>	<b>71</b>	<b>0%</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>AIR EVAC SUMMARY</b>										
		# of Flights	Patients							
			Total	EVENT			DNBI			
				CF	HNSF	LN	CF	HNSF	LN	
	0	0	0	0	0	0	0	0	0	
MEDEVAC		0								
TACTICAL EVAC		0								
STRATEVAC		0								
<b>Regional Command Comments:</b>										

**ANNEX D TO  
AMedP-9.2**

	10-Feb-08 PM					
Line No	Reporting MMF:	Date Admitted	Date Discharged:	Discharged To:	PT Number & Name	Nationality / Service Category ID
1	R3 MMF	09-Feb-08	10-Feb-08	LRMC	123-45-6789, Cpl John Doe	ISAF/CAN
2	R3 MMF					
3	R3 MMF					
4	R3 MMF					
5	R3 MMF					
6						
7						
8						
9						

**TAB 2**

MM(S)	PT Status & Treatment Comments Injury Cause	Injury Categor	Injury Type	Length of Stay (days)	REMARKS
MM(S)02-09A	Malaria	Litter	NBI	1	ICU

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**APPENDIX 9 TO ANNEX D: USOP 1100-9: VISITORS FOR PATIENTS**

Reference: A. USOP 7500-1

1. This USOP outlines the procedures to be followed when visitors request to visit a patient that is admitted to the MMU. It covers requests from Coalition Force, Local National (LN) and Host Nation Security Force (HNSF) or Government Official VIP.

2. As per reference A, the following will determine whether a patient can accept visitors or not:

- a. Contact Charge Nurse: Verify with the ward to ensure the visit will not interfere with patient care;
- b. Contact Patient Nurse to be sure the patient can have visitors; and
- c. Once the visitor is granted access by the Ward, either the PT liaison/pad clerk or charge nurse will come and escort the visitor(s). All visitors require a visitor pass, see below.

3. Coalition Force Visitors for Patients. Whenever visitors present themselves at the TOC the following must be verified before the visitor will be allowed access to the ward to visit the patient:

- a. Charge Nurse. Verify with the ward to ensure the visit will not interfere with patient care;
- b. Patient liaison. Verify with the PT nurse that the ward can accept visitors from a work management perspective. Even though the visitors may be Coalition Forces, the ward restricts the number of individuals a patient can receive at a time due to the physical size of the rooms; and
- c. Once the visitor is granted access by the Ward, either the PT liaison or charge nurse will come and escort the visitor(s).

4. Visitors for Local National (LN) patients. The following describes the two processes to follow when a LN requests to visit another LN patient. Visits will be kept to the facilities visiting hours. Note that in all cases, the patient liaison officer is responsible to brief the Standing ward guard that there will be a new visitor in the facility. All visitors will be screened by the Main Gate security team:

- a. First time visitors. Before a LN visitor is to be picked-up and brought to MMU, the visitor is to be positively identified by patient. After positive identification is made the Tactical Operation Centre duty officer (TOC DO) is to then do the following:
  - (1) Call EVAC and inform them of the situation. Ask them to come over to the TOC in order to pick up the camera;

- (2) EVAC will go to the main gate, take a picture of the visitor(s), and return to TOC to print the picture;
  - (3) The picture will then be shown to the patient, who via the interpreter should positively identify the visitor(s);
  - (4) After the visitor's picture is positively identified the DO will create a TOC Visitor Pass including the fol; Name of the visitor, patient's name, time period that the visitor will be visiting and the TOC DO's signature. A photocopy is then taken and placed on the clipboard in the TOC for future reference. The original is given to the visitor so they may visit again; and
  - (5) EVAC will go back to the Main Gate to pick up the visitor and bring them back to the R3 following the remainder of the instructions listed below in para b.
- b. LN Visitors with TOC Visitor Pass. The following steps apply should a LN already be in possession of a TOC visitor pass from a previous visit:
- (1) Charge nurse and Patient nurse approval that a certain patient can accept visitors;
  - (2) EVAC will report to the TOC to obtain the photocopied TOC visitor pass for the LN present at the Main Gate to verify identity;
  - (3) EVAC will pick up the LN visitor and report to TOC to obtain a visitor pass, located in TOC; and
  - (4) LN visitor will wait outside the TOC until the Charge nurse or the Pt liaison links up and exchanges custody of the LN visitor to the ward.
5. Visitor pass. All visitors require a visitor pass, located in the TOC:
- a. Passes are located inside the front door of the TOC, each pass is color-coded to signify if the visitor is escorted (red) or unescorted (yellow);
  - b. All visitors will be required to hand in a piece of ID to get a pass; and
  - c. If they do not have ID, have the escort hand in his ID.
6. Visiting Hours. Visiting hours are from 1000-1200, 1300-1500, 1800-2000, all other times beyond this are at the discretion of the charge nurse or OC.
7. Responsibilities – Additional Guidelines:
- a. All MMU Staff:
    - (1) Number of visitors:

- (a) Unless otherwise directed by Commanding Officer, Task Force Surgeon, Officer Commanding (OC) In-Patient Services, the number of visitors shall be limited to 2 per patient at a time in the Intermediate Care Ward (ICW) and 1 visitor per patient at a time in the Intensive Care Unit (ICU);
  - (b) Diligence must be given to the overall space in the facility when considering the number of visitors and its impact on the ability for staff to deliver quality health care; and
  - (c) For LN visitors, the ability of the guard to perform his/her duties and number/availability of additional guards to observe these visitors must be considered before allowing further visitors in the facility.
- (2) Safety:
- (a) All LN visitors are to be cleared at the Main Gate of weapons, cell phones, and other electronic video and/or communication equipment;
  - (b) All LN visitors are to be guarded; and
  - (c) If the safety of the staff or patients is ever in jeopardy, all visitors will be removed from the facility IAW ref C.
- (3) Detainees: Any visitor(s) for detainee(s) can only occur under the direct authority of the JTF Commander.
- (4) Visitors in the Intensive Care Unit:
- (a) Due to the fact that ICU patient cannot identify their visitors, their identity will be verified before they are allowed access to the ICU by an entrusted official (Force official specially nominated to do so) and the OC must be notified; and
  - (b) VIP patient. No LN visitors will be allowed unless their identity is previously verified by an entrusted Force official.

Visitors will be limited to a minimum to preserve patient dignity. OC In-Patients can deny access to VIP patient at any time.

- (5) Visitors in the Trauma Bays:
- (a) In almost all circumstances, visitors will be asked to wait for the patient to be moved to the Ward or the ICU before being allowed to visit a patient;

- (b) Visitors are not allowed in the trauma bays inside the red square unless directed by the Trauma Team Leader for the purpose of organizing home call or for LN to get information /consent on the treatment of a family member;
  - (c) LN visitors shall have an interpreter present, if possible, to allow questions and provide comfort, and;
  - (d) No more than 2 visitors will be allowed in a trauma bay at any given time unless otherwise directed by the CO, OC in Patient Services.
- (6) Death of a patient:
- (a) Families of LN and some unit's members could be allowed the opportunity to grieve and visit the patient depending on circumstance;
  - (b) The number of visitors at a given time is to be at the discretion of the CO, OC Role In Patient Services and/or designate after hours Duty Medical Officer, Charge Nurse and based on current tempo, space, disruption of health care provision, and availability of guard (for LN visitors); and
  - (c) Support structures necessary to assist in the grieving process are to be implemented, through the TOC and/or with the interpreters, and should not prevent visitors from being present.
- (7) Pictures in Role 3. Pictures in the MMU are strictly controlled and subjected to USOP 7500-1.

8. Special Circumstances (LN visitors):

- a. Critically unstable/palliative patient. All due diligence is to be considered to provide the family and patient the opportunity to be at the bedside. Therefore, visiting hours and/or length of visit can be tailored to meet their needs at the discretion of the physician and charge nurse.

Non-family members that request to see the patient will be at the discretion of the Officer In Charge (OIC);

- b. Minors. As the MMU can be a frightening and daunting environment for a minor (under 18), a family member can stay with the patient 24 and 7 if so desired and space within the facility allows under the direction of the charge nurse or OIC; and

- c. Political/VIP visitors. Under the direction of the CO, visiting hours can be amended to accommodate this group. For after hours, direction is to be provided by the duty MO in consultation with the duty O (TOC) and charge nurse. Facility demands such as disruption, workload, space, availability of guards, and feasibility of their claim needs to be considered and/or verified in the determination of these timings. Otherwise their visiting are the same as Para 6. The chain of command for coalition patients are to given the same due process as given to NATO.

9. HN Security Force VIPs. On occasion, HN Security Force VIPs or government officials will request to visit patients being treated at the MMU. In situations such as these expect the following:

- a. Initial warning of visit by either Commander's Executive Assistant or cultural awareness advisor of when to expect the visit;
- b. VIP will be escorted to the TOC either with a military member or cultural awareness advisor; and
- c. Note that in some cases HN Security Force VIPs will arrive with no notice or escort. When these situations occur ensure, TOC personnel must ensure that the VIPs identity is verified before he is allowed access to the ward and the OC must be made aware.

10. Visitors Return Transport. At the conclusion of the patient visit the following will occur with all types of visits, with the exception of ISAF visitors or HN Security Force escorted visitors:

- a. TOC will be informed that the visit is concluded, and passes turned in;
- b. EVAC is notified to report to the ward IOT escort the visitor from the facility back to the Main Gate; and
- c. The visitor is driven back to the Main Gate.

OPI: OC MMU

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<p><b>APPENDIX 10 TO ANNEX D: USOP 1100-10: DUTY RUNNER / DRIVER</b></p>
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**APPENDIX 10 TO ANNEX D: USOP 1100-10: DUTY RUNNER / DRIVER**

1. General. The purpose of this USOP is to outline the duties of the Duty Runner/Driver (DR/D) position.
2. Rotation. The DR/D responsibility will rotate throughout the HQ and facility staff and will include all military personnel Capt / Warrant Officer and below. Personnel on duty, specialists and personnel who are frequently called in for clinical care should not normally be selected for this duty. Shift schedules will be maintained by the Senior TOC O however they will be issued by the Deputy Commanding Officer in coordination with OC in Patient Services. Any changes to the shift schedule must be approved by the applicable section OC.
3. Hours. The DR/D shift will be a 24 hour period and will run from 1830 – 1830 hours. The DR/D will be on 5 minutes notice to move (NTM) during this period. Normally during regular work hours 0800-1700 hours the DR/D will be able to fulfill their regular tasks as long as they are available within 5 minutes and in contact with the TOC by a reliable communication means. The DR/D may sleep in the duty MO trailer during their shift when they are not required but will remain on 5 minutes Notice to Move (NTM). The DR/D may not eat at the dining facility and will take their meals at the MMF. If breaks are required when the DR/D will not be able to meet the 5 min NTM readiness state (Ex: meetings, showering) a suitable replacement will be provided by the member's section.
4. Duties. The DR/D will report to the TOC O for direction and orientation as of 1830 hours on their assigned duty day, they will perform this duty until relieved by the next DR/D. The primary duty of the DR/D is to contact and MMF staff as required by the TOC O for emergencies or high priority communications. The DR/D will be required to pick up recalled staff members in order to reduce response time. In the interest of staff safety, after working hours the DR/D will be available to return recalled staff to their barracks if they do not have a higher priority task. The DR/D will not normally be used for meal runs and other administrative non-emergency tasks.
5. Secondary Duties. The DR/D is responsible to ensure that they perform a vehicle inspection at the beginning of their shift to include checks of all fluids, belts, hoses, exterior and interior damage, cleanliness and that the gas tank is no less than half full. During periods of heavy traffic to the TOC the DR/D may be used as a runner within the facility as well as responding to questions at the door.
6. MASCAL and Multiple Casualties. In situations where the DR/D is a clinician, the mbr will not take on a clinical function unless directed by the TOC O or relieved by another Runner / Driver
7. Chain of Command. Section commanders will be responsible for ensuring that their personnel report for duty as per the schedule. If required and appropriate, Sect

Comds may grant compensatory time off to allow personnel to return to a normal sleep schedule or for pers admin after performing the DR/D function.

OPI: Adj  
Effective:  
Revised:



**APPENDIX 11 TO ANNEX D: USOP 1100-11: EVACUATION PROCEDURES**

PURPOSE

1. The purpose of this USOP is to outline those procedures required to ensure a swift reaction to incidents, such as close impact, fire, and /or a suspicious package in order that the safety of patients is maintained and that their subsequent evacuation is conducted appropriately.

BACKGROUND

2. The requirement to evacuate patients to an alternate facility is usually dictated by the type of threat to the MMU. Any potential threat that could endanger the lives of patients and staff, which includes fire, improvised explosive device (IED) or threat of attack by airborne devices such as rockets or mortars will necessitate an orderly evacuation. Patients already in the facility may be moved depending on the nature of the threat. Due to the nature of the threat and the close proximity of the overflow tents it may not be possible to carry on operations within the MMU and an alternate temporary location has been designated at \_\_\_\_\_ located at \_\_\_\_\_. Should the \_\_\_\_\_ not be available, the \_\_\_\_\_ located in \_\_\_\_\_ will be the back-up location.

POLICY AND PROCEDURES

3. General. This evacuation plan is concerned with any situation that threatens the MMU. Fire Orders are issued as a separate document and will be posted in the Role 3 facility, the HQ tent and the Primary Care tent. The threats are broken down into three major threats, fire, close impact and suspicious package.

4. Actions on discovery on fires

a. Individual. Upon discovering the fire, the individual will immediately yell "FIRE! FIRE! FIRE!" to alert the staff in the facility. Next the individual will try and extinguish the fire with the nearest firefighting equipment. In the event that this is not successful, the orderly evacuation of the facility will take place.

b. TOC:

- (1) Activate Facility Evacuation plan in accordance with (IAW) Tab A;
- (2) Inform In Patient Services Staff that there is a fire and to prepare for evacuation;
- (3) Inform Evacuation Platoon that there is a fire and that patients may need to be evacuated;
- (4) Alert RC HQ Med Ops Staff of the evacuation procedures in place;

- (5) Alert the MMU Chain of Command;
  - (6) Secure any sensitive items or materials; and
  - (7) Move TOC to alternate location.
- c. Out Patient Services. Primary Care staff will begin preparing patients IAW Tab A.
- d. Evacuation Platoon. Evacuation Platoon will ready ambulances and personnel to move patients IAW Tab B.
5. Actions on discovery of suspicious package
- a. Individual. Upon discovering the suspicious package will secure the area and notify the TOC. Due to the nature of this threat it is imperative that members remain vigilant in their areas of responsibility to ensure that nothing is out of place nor are there items that cannot be accounted for in the facility.
  - b. TOC:
    - (1) Activate Facility Evacuation plan IAW Tab A;
    - (2) Inform In Patient Services Staff that there is a suspicious package and to prepare for evacuation;
    - (3) Inform Evacuation Platoon that there is a suspicious package and that patients may need to be evacuated;
    - (4) Inform Task Force elements that the facility is being evacuated due to a suspicious package;
    - (5) Alert RC HQ Med Ops Staff of the evacuation procedures in place;
    - (6) Move TOC to alternate location;
    - (7) Coordinate MEDEVAC/STRATEVAC for patients as directed by SMA; and
    - (8) Secure any sensitive items or materials.
  - c. Out Patient Services. Staff will begin preparing patients IAW Tab A to be evacuated to alternate location.
  - d. Evacuation Platoon. Evacuation Platoon will ready ambulances and personnel to move patients to an alternate location IAW Tab B.

- e. All Non-Clinical Personnel. All non-clinical personnel will report to the Company Sergeant Major and secure the area to an initial cordon of 300 meters. This cordon may be expanded upon arrival of Quick Reaction Force (QRF) and EOD personnel. There will be no movement allowed into the facility from this moment unless directed by the EOD personnel; and
- f. QRF. The QRF will move in and assume control of the cordon and await arrival of the EOD team.

6. Actions on close impact or base alarm

a. Individual.

(1) Actions at night:

- (a) Seek immediate cover wherever you are, preferably in bunkers if available. Due to low availability of bunkers and low probability of bunkers and low probability of follow on attack, if you are in your tent remain in your tent and stay dispersed; and
- (b) Account for all personnel in your room. When it is safe, the senior member of the barrack bloc will report to Regimental Sergeant Major, and section heads will report to the MMU TOC.

(2) Actions during Working Hours.

- (a) Seek immediate cover wherever you are, go to bunker if one is in the immediate vicinity; and
- (b) If not at your place of duty, report immediately.

b. Company Sergeant Major.

After business hours:

- (1) Meet tent reps at if event occurs at night;
- (2) Take roll call at facility if attack occurs during daylight hours;
- (3) Send report to Ops that pers have been accounted for within the MMU; and
- (4) Initiate search as required.

c. TOC:

- (1) Activate Facility Evacuation plan IAW Annex A if required;
- (2) Inform In Patient Services Staff to prepare for evacuation;

- (3) Inform Evacuation Platoon to prepare for evacuation;
  - (4) Inform all TF elms that the facility is being evacuated if required;
  - (5) Alert RC Med Ops Staff of the evacuation;
  - (6) Alert the MMU Chain of Command;
  - (7) Move TOC to alternate location located at RC Med Ops;
  - (8) Coordinate MEDEVAC/STRATEVAC for patients as directed by SMA; and
  - (9) Secure any sensitive items or materials.
- d. Out Patient Services. Immediately cover patients with blast blankets. Blast blankets are located in each Exam Bays. Prepare patients to move to bunker. Staff will then begin preparing patients IAW Annex A to be evacuated to alternate location if required;
  - e. Evacuation Platoon. Evacuation Platoon will ready ambulances and personnel to move patients to an alternate location IAW Ref B;
  - f. II Non-Clinical Personnel. All non-clinical personnel will report to CSM and secure the area to an initial cordon of 300 meters. Non-clinical pers will also be used as litter teams to evacuate the facility. This cordon may be expanded upon arrival of QRF and MPs. There will be no movement allowed into the facility from this moment unless directed by the MPs; and
  - g. QRF. The QRF will move in and assume control of the cordon and await arrival of the EOD team.
7. Location of Bunkers. Bunkers at the R3 MMU are as follows:
- a. Patient Bunker – located; and
  - c. Staff Bunker – Located.

#### POST INCIDENT RESPONSE

8. Collection of casualty information and location, incident reporting, coordination of MEDEVAC/STRATEVAC as required and after action review will all be conducted immediately following the evacuation.

COMMAND AND SIGNALS

9. Command. As follows:
  - a. Incident Command. Commanding Officer;
  - b. Incident Coordination. Deputy Commanding Officer;
  - c. Senior Medical Authority. Senior Gen Surg;
  - d. TOC Command. TOC Duty Officer;
  - e. Outer Perimeter Command. Regimental Sergeant Major;
  - f. Traffic Control. In Charge Service Platoon;
  - g. Crowd Control. In Charge Service Platoon;
  - h. Evac Non Commissioned Officer; and
  - i. Senior Medical Technician.
10. Communication. Requests for support shall be made through MMU TOC.
  - a. Frequencies.
  - b. Telephones: MMU TOC: RC Ops  
RC HQ Med Ops Staff. ;  
RC Med Regulating Officer; and  
Task Force Med Ops TOC
12. Helicopter Landing Site.

Primary Care Plan for Evacuation, see following pages

Evacuation Platoon Plan for Evacuation, see following pages

OPI: RSM MMU

Effective Date:

Reviewed

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<b>APPENDIX 11 TAB A - PRIMARY CARE PLAN FOR EVACUATION</b>
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1. In the event of a requirement to evacuate the Primary Care Patient Areas of the hospital for fire, suspicious package, close impact/base alarm the following guidance is provided.
2. The primary emergency exit is double door entrance off the Primary Care. The secondary exit is the staff exit at the back of Primary Care. Rally point for both exits will be (to be determined in the theater of operation).
3. General Evacuation Procedures
  - a. Once notified by the TOC of the need to evacuate to an alternate location the Non Commissioned Officer In Charge (NCO I/C) will:
    - (1) Request ambulances and staff vehicles be positioned to move patients— ambulances at trauma bay doors, vehicles at rally point;
    - (2) Notify the ward, that ambulances and vehicles are at location and ready to be loaded;
    - (3) Assist staff to move patients to ambulances and vehicles for movement to alternate location;
    - (4) Account for all patients and staff once move to alternate location has been completed and notify the TOC; and
    - (5) Wait for further direction from the TOC.
  - b. All staff will:
    - (1) Assist for patients move (cover with blankets, etc);
    - (2) Prepare ambulances for needed patient equipment for move with patient;
      - (a) Load needed immediate patient supplies (time dependent) for move with patient;
      - (b) Assist with the move of ambulatory and wheelchair patients to the rally point with staff, move litter patients out the trauma bay doors to ambulances with accompanying staff; and
    - (3) Assist with loading of patients into ambulances and vehicles for movement to alternate location;

- (4) Assist with the unloading of patients at alternate location and return to Role 3 to continue with the evacuation of patients; and
- (5) Wait for further direction from the NCO I/C Primary Care.



**APPENDIX 11 TAB B - EVACUATION PLATOON PLAN FOR EVACUATION**

1. In the event of a close impact, fire, and /or a suspicious package at MMU, the evacuation platoon will put the following plan into effect for the evacuation of Medical Inspection Room (MIR) (Role 1) personnel and patients.
2. Upon notification of a workplace hazard, members will immediately notify the shift leader, the hospital warrant officer (if available), and the Duty Medical Officer (MO). The Duty MO and shift leader will organize all assigned personnel to move patient from Primary Care to the pre-designated hospital rally point. In addition, the shift leader, with the hospital warrant officer (if available) providing oversight, will determine if there is time to secure weapons and aid bags. A roll call will be taken at the pre-designated rally point.
3. After personnel have been secured, the shift leader and the hospital warrant officer (if available) will determine whether the field ambulances can be safely removed from the MIR to the designated rally point. If the vehicles are safe to move, they may be used for the transport MMF patients (see below).
4. The evacuation platoon, after caring for MIR patients, will also make themselves available as a ready labor pool for the evacuation of other hospital personnel and patients at the direction of the hospital warrant officer, or, if he/she is not available, under the direction of the senior ranking Non Commissioned Member or appointed delegate.
5. During a hospital evacuation, the ability to continue to see patients is vital and necessary. As soon as is practicable, a temporary treatment area will be established at a place convenient to the pre-designated hospital rally point. The members of the evacuation platoon will provide patient treatment and transport to and from this site as manpower allows.
6. Upon cessation of the threat posed by the event, the members of the evacuation platoon will return to their place of duty at the discretion of the senior hospital officer.
7. In the event of a close impact, fire, and /or a suspicious package at MMU, the evacuation platoon will put the following plan into effect for the evacuation of Medical Inspection Room (MIR) (Role 1) personnel and patients.
8. Upon notification of a workplace hazard, members will immediately notify the shift leader, the hospital warrant officer (if available), and the Duty Medical Officer (MO). The Duty MO and shift leader will organize all assigned personnel to move patient from Primary Care to the pre-designated hospital rally point. In addition, the shift leader, with the hospital warrant officer (if available) providing oversight, will determine if there is time to secure weapons and aid bags. A roll call will be taken at the pre-designated rally point.
9. After personnel have been secured, the shift leader and the hospital warrant officer (if available) will determine whether the field ambulances can be safely removed

from the MIR to the designated rally point. If the vehicles are safe to move, they may be used for the transport MMF patients (see below).

10. The evacuation platoon, after caring for MIR patients, will also make themselves available as a ready labor pool for the evacuation of other hospital personnel and patients at the direction of the hospital warrant officer, or, if he/she is not available, under the direction of the senior ranking Non Commissioned Member or appointed delegate.

11. During a hospital evacuation, the ability to continue to see patients is vital and necessary. As soon as is practicable, a temporary treatment area will be established at a place convenient to the pre-designated hospital rally point. The members of the evacuation platoon will provide patient treatment and transport to and from this site as manpower allows.

12. Upon cessation of the threat posed by the event, the members of the evacuation platoon will return to their place of duty at the discretion of the senior hospital officer.

**APPENDIX 12 TO ANNEX D:  
USOP 1400-1: CLEANING PROCEDURE FOR PACES CONTAMINATED WITH  
HUMAN BIOLOGICAL WASTE**

References: A. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm> Guidelines for Environmental Infection Control in health-Care Facilities: Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee, June 6, 2003  
B. [www.osha.gov](http://www.osha.gov). Standard 1910  
C. USOP 1400-5, Biomedical Waste

**PURPOSE**

1. This USOP outlines the appropriate steps to clean and sanitize human biological waste from spaces. This applies to any living or workspace involved with death or serious injury. Proper handling and management of human biological waste is essential to reduce the possibility of transmission of infectious disease to personnel.

**DEFINITIONS**

2. The following definitions are pertinent to this USOP (references A and B):
- a. Human Biological Waste (HBW) is waste that belongs to one or more of the following categories:
    - (1) Human anatomic waste:
      - (a) Human tissues.
    - b. Organs; and
      - (a) Body parts.
    - (2) Body fluid waste:
      - (a) Human fluid blood and blood products;
      - (b) Items saturated or dripping with blood; and
      - (c) Body fluids.

**EXECUTION**

3. The first step is for the Camp Sergeant Major (CSM) or the MMU TOC Duty Officer to contact the Preventive Medicine (PMed) Department advising them that an incident has occurred and HBW is present in a space. This should be done as expeditiously as possible under the circumstances so that preparations can be made and necessary resources gathered. At this time, the PMed section may request additional

resources in the form of manpower or logistical assets. The CSM will provide such resources to the best of his abilities.

4. The circumstances surrounding HBW in a space will almost always require investigation by other authorities. Once this is complete and the scene or space has been “released”, a PMed Tech shall inspect the space, appropriately protected from biological hazards, to determine the extent of cleanup of the space and any equipment, furnishings, personal kit, etc.

5. Cleaning of spaces or equipment having been involved with death or a serious injury: The following course of action should be taken:

- a. The PMed Tech and/or those designated to work with the PMed Techs, will don suitable personal protective equipment (PPE). This may include:
  - (1) Fluid impermeable coveralls (i.e., Tyvek suit);
  - (2) Disposable (single use) gloves such as surgical or examination gloves, which shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised;
  - (3) Particulate respirators N95: particulate respirators are intended to minimize but not eliminate wearer exposure to specific airborne particles. These respirators must meet the CDC guidelines for TB exposure control, and should be changed immediately should they come in contact with blood or fluids; and
  - (4) Safety glasses/goggles.
- b. Cleaning of HBW shall be achieved by spraying all affected surfaces contaminated with HBW with a bleach solution, 1:10 dilution (500 ppm) or other suitable disinfecting solution. Porous contaminated surfaces shall be considered biomedical waste and should be disposed of following guidelines at Ref C. After 20 minutes the affected areas can be wiped clean with disposable towels or rags;
- c. All dirt rags and towels shall be disposed of IAW Ref C. Disposable PPE shall be treated as biomedical waste and disposed of as per Ref Non-disposable equipment shall be cleaned with an appropriate disinfectant (1:10 bleach in water solution) and air dried;
- d. All individuals involved with cleaning of the space shall wash hands and any other exposed skin with soap and water; and
- e. The space will then be turned back to the holding unit for general cleaning.

6. The following list of items shall be provided by the MMU PMed Section:

Personal Protective Equipment (PPE);

- a. Bristle brush;
- b. Biohazard and regular garbage bags;
- c. Disinfectant solution (i.e. 1:100 dilution chlorine); and
- d. Wiping cloths or rags.

**COMMAND AND SIGNALS**

7. PMed contact information as follows:

- a. PMed CSN phone; and
- b. PMed cell – .

c. **CONCLUSION**

8. This policy is subject to review and change as required to conform to current medical practices and pertinent legislation.

OPI: Preventive Medicine Department

Effective:

Revised:

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<p style="text-align: center;"><b>APPENDIX 13 TO ANNEX D: USOP 1400-2: HANDLING MERCURY SPILLS</b></p>
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References: A. Mercury and the Environment (Cleaning up Small Mercury Spills) website <http://www.ec.gc.ca/MERCURY/EN/cu.cfm>

B. Draft FSOP Handling of Dental Amalgam

### PURPOSE

1. Mercury is a toxic element that can significantly impact human and environmental health; even small mercury spills are hazardous and should be cleaned up with caution. This USOP discusses the method for cleaning up after a mercury spill in accordance with Ref A.

Note: Spills of dental amalgam, which contains mercury, are discussed at Ref B.

### DEFINITIONS

2. The following definitions are pertinent to this USOP:
- a. Hazardous Material (HAZMAT): any material that, if handled improperly, can endanger human health and well-being, the environment, or equipment. Some examples of HAZMAT are poisons, corrosive agents, flammable substances, ammunition and explosives; and
  - b. Mercury: a heavy, silvery-white liquid metallic element, used in some thermometers and barometers. Mercury, known also by its elemental symbol Hg, is the only metal that is liquid when at room temperature. It is used in industry e.g. thermometers, barometers and batteries. Prior to 1990 it was used as an anti-mildew agent in paint. It is also used in dental amalgams however, once the dental amalgam has been placed in the mouth, it does not pose a health risk.

### THE MERCURY HAZARD

3. It is important to recognize the hazard presented by a mercury spill. Mercury by any route is toxic. Mercury may be introduced into the body via the following routes:
- a. Inhalation. Mercury evaporates at room temperature. Mercury vapor is extremely toxic. Liquid mercury volatilizes easily to form a poisonous, colorless and odorless vapor when spilled. If inhaled, this vapor is rapidly absorbed through the lungs of an exposed individual;
  - b. Absorption. Mercury absorbs readily into skin tissues;
  - c. Injection. Mercury may be introduced into open wounds in events such as a thermometer breaking, etc.; and

- d. Other routes of entry. Such as fish ingestion, are not relevant in the workplace, and therefore are not considered in this SOP.

#### EQUIPMENT

4. Items listed below will be required to clean up a mercury spill. Please note, any item used in the process of cleaning up a mercury spill, must be properly disposed of afterwards:

- a. Rubber gloves;
- b. Protective eyewear or safety glasses;
- c. Disposable gown;
- d. Eye dropper;
- e. large trash bags;
- f. Large tray or box;
- g. Plastic bags with a zipper seal;
- h. Rags;
- i. Tape: duct, masking or packing;
- j. Stiff paper;
- k. Plastic dust pan;
- l. Wide-mouth containers with tight fitting lids;
- m. Flashlight; and
- n. Commercially available mercury spill kit.

#### EXECUTION

- 5. Step 1 – Determine the Extent of the Spill:
  - a. Determine if the size of spill can be safely cleaned up with available personnel or if the spill is of sufficient quantity to warrant calling in additional resources to assist; and
  - b. If additional resources are required contact the Fire Department.



6. Step 2 – Preparation:
  - a. Remove jewelry because it can form bonds with the recur (amalgamate);
  - b. Put on disposable gown or change into old clothes that can be discarded; and
  - c. Put on rubber gloves and safety glasses.
7. Step 3 – Contain the Spill:
  - a. Check to see if anyone, or their apparel or any porous household items (such as floor mats) have been splashed with mercury. If so, contaminated items should be removed and placed in a double sealable bag. Mercury on the skin should be wiped off and also placed in the plastic bag;
  - b. Evacuate the area;
  - c. Open windows and exterior doors to ventilate the area, since the danger of mercury exposure is much greater, in poorly ventilated areas;
  - d. Turn off ventilation, heating or air conditioning systems, that could circulate air from the site of the spill, to other areas of the building;
  - e. Turn down the thermostat. Lowering the temperature decreases the amount of mercury vapor that will enter the air;
  - f. Use stiff paper to push the drops together; and
  - g. Stop the spread of the spill by blocking it off with rags. Mercury droplets should be prevented from entering cracks in the floor, crevices and drains.
8. Step 4 – Clean Up:
  - a. Follow the instructions on a mercury spill kit if you have one;
  - b. Carefully clean up any broken glass. Wear rubber gloves to avoid contact with mercury and to prevent cuts. Place the glass in a sharps container;
  - c. Work from the outside of the spill area towards the center. Use a mercury vacuum, or using stiff paper, slide any droplet of liquid mercury onto a plastic dustpan, away from any carpet or other porous material;
  - d. Use a flashlight to illuminate the mercury spill and to help spot small droplets. An eyedropper or an adhesive strip can be used to pick up any smaller droplets;
  - e. Pour collected mercury into a large mouth container slowly and carefully. This should be done over a box or tray lined with plastic to contain spillage. Close

the container with an airtight lid and seal with tape. Place inside a sealable bag and seal;

- f. Residual mercury can be removed by wiping with a vinegar-soaked swab followed by peroxide. The swabs should then be placed in an airtight container or sealable bag;
- g. Remove clothing worn during clean up and all other items that may have come into contact with mercury, such as shoes, carpeting and clean up materials. Double or triple wrap all of the above, using plastic or sealable bags; and
- h. Thoroughly wash and rinse humans or animals that came into contact with the mercury using an alkaline soap.

9. Step 5 – Disposal:

- a. Make sure that all bags with contaminated items and mercury are double wrapped. Label these plastic bags “Elemental Mercury: Hazardous Waste”,
- b. Label any containers with contaminated washing water in the same fashion;
- c. Ensure contaminated clothing is not laundered in a domestic washing machine. Mercury may contaminate the machine and pollute the sewage system;
- d. Refrain from vacuuming a mercury spill. If used, vacuums may become contaminated and therefore may need to be discarded;
- e. Refrain from using a broom or brush to clean-up mercury spills. Sweeping or brushing up a spill will scatter mercury droplets, making them harder to find and clean-up;
- f. Never pour mercury down the drain. The element may collect in the Strap of the drain and pollute the sewage system or the septic tank. Additionally, never throw mercury contaminated items in the garbage. Mercury may be emitted as a vapor from landfill sites or from waste incinerators; and
- g. Contact the Preventive Medicine Department for further disposal instructions.

10. Step 6 – Follow Up:

- b. Continue to ventilate the area with outside air using fans for a minimum of two days if possible. In an office building, increase the air exchange rate for one day; and
- c. In extreme exposure cases it may be necessary to conduct blood and urine tests. Please discuss with a physician on a case by case basis.

11. PMed contact information as follows:

- a. PMed CSN phone:; and
- b. IC PMed cellular:

12. This policy is subject to review and change as required to conform to current occupational health and safety standards.

OPI: Preventive Medicine Department

Effective:

Revised:

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**APPENDIX 14 TO ANNEX D:  
USOP 1400-3: BIOMEDICAL WASTE DISPOSAL**

PURPOSE

1. Proper handling and management of biomedical waste is important to reduce the possibility of transmission of infectious disease from waste to personnel. Therefore, it is imperative that medical personnel know the proper methods for handling and disposing of the waste generated by medical procedures. This USOP lays out the basic handling and storage requirements of biomedical waste at the MMF for all departments.

DEFINITIONS

2. The following definitions are relevant to this policy:

- a. Biomedical waste. Refers to waste that is generated by healthcare facilities and includes human anatomical waste, microbiology laboratory waste and all disposable items that are soiled with body fluids;
- b. Contaminated sharps. Are materials that can puncture, penetrate or cut the skin, which have come in contact with a body fluid or micro-organisms as per, needles, lancets, scalpels and laboratory glass that is broken or may be easily broken;
- c. Body fluid waste. Human blood and blood products, items saturated or dripping with blood, or body fluids contaminated with blood. This does not include urine or feces;
- d. Human anatomic waste. Human tissues, organs and all body parts;
- e. Incineration. In order to ensure safe destruction of pathogens and reduce waste volume, all health care waste generated by TF medical facilities will be incinerated.
- f. Pharmaceutical waste. Pharmaceutical products, such as drugs and medicinal chemicals, that are no longer usable in client treatment, that have become outdated or contaminated, have been stored improperly, or are no longer required;
- g. Refrigerated storage. Secured storage of wastes at a temperature of 4°C or lower;
- h. Storage. The accumulation of wastes after segregation in a specified container; and
- i. Waste sharps. Clinical and laboratory materials consisting of needles, syringes, blades, ampoules, vials or laboratory glass, capable of causing cuts.

j. EXECUTION

3. The following steps are to be followed by each department for disposing of biomedical waste within the MMU biomedical sea-container:

- a. Ensure waste is bagged properly, all biomedical waste should be either in a sealed sharps container or double-bagged in biohazard bags;
- b. Sign for the biomedical key held in the key press at MMF Tactical Operations Centre (TOC);
- c. All personnel entering the Biohazard sea container must wear Personal Protective Equipment. Gloves and boot covers are to be worn when placing the waste. Gloves, boots covers, impermeable gown, mask with visor and cap are to be worn with any other handling of waste;
- d. Place biomedical waste within the refrigerated storage sea-container. Ensure that the bags are on shelves to the right. Sharps containers are on the shelves to the left and blood bank boxes are underneath the sharps containers. All containers and bags shut with packing tape; and with any blood products place a solidifier in the bag with it;
- e. Mark the waste container with the department name, initials and date; and
- f. Re-secure the sea-container and return the key to the MMU TOC.

4. All MMU personnel involved in the handling and disposing of biomedical waste should be familiar with the procedures required to properly dispose of biomedical waste. The ward Master /Section Senior shall be responsible to assign members for biomedical disposal. Members assigned to this duty shall:

- a. Conduct biomedical waste transfer to the Burn Pit each Monday and Fridays
- b. Obtain and sign for the biomedical sea container key from the TOC;
- c. Obtain a suitable vehicle to tow biohazard materials trailer;
- d. Wear personal protective gear when handling this waste. The following items are mandatory:
  - (1) Disposable gown;
  - (2) OR booties;
  - (3) Mask – a mask with a shield is preferred, if no shield, then wear ballistic eye-wear; and
  - (4) An extra biohazard bag for the contaminated personal protective gear.
- e. Practical steps to follow:

- (1) During the loading of biomedical waste into the vehicle personnel protective gear must be worn;
- (2) Re-secure the sea container and return key to TOC;
- (3) Remove personnel protective gear before entering the cab of the vehicle, set aside to be reused at the Burn Pit when unloading the biomedical waste. If gross contamination occurs during loading, discard as biomedical waste and bring new personnel protective gear to Burn Pit;
- (4) Drive to burn pit and ask for the burn pit manager;
- (5) Follow the burn pit manager's direction. This will include going to the weigh station. Don personnel protective gear and off-load accordingly to the manager's directions; and
- (6) After disposing of the waste, return vehicle and keys.

5. Pharmaceutical waste shall be disposed of using the same process however; it shall be bagged or boxed separately from other waste but stored in the same biomedical sea-container.

#### RESPONSIBILITIES

6. All personnel disposing of biomedical waste are responsible for:
  - a. Proper handling of the waste; and
  - b. Proper disposing of the waste as outlined within this FSOP.
7. PMed contact information is as follows:
  - a. PMed CSN phone:; and
  - b. IC PMed cellular:

#### CONCLUSION

8. This policy is subject to review and change as required to conform to current medical practices and Federal, Provincial, and Municipal legislation.

OPI: Operating Room Dept, MMU

Effective:

Revised:

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<p style="text-align: center;"><b>APPENDIX 15 TO ANNEX D</b> <b>USOP: 1400-4: RABIES AND ANIMAL BITE MANAGEMENT</b></p>
---

References: A. *National standards*  
B. Control of Communicable Diseases Manual, 17<sup>th</sup> Edition

### DEFINITIONS

1. For the purpose of this USOP the following definitions are to be implemented:
  - a. Rabies. An almost invariably fatal acute viral infection, which can be transmitted to humans by infected animals (often dogs or bats) via a bite or by the exposure of broken skin to an infected animal's saliva; and
  - b. Victim. The person bitten or scratched by a suspected animal.

### GENERAL

2. This USOP covers the steps to be taken in the event of an animal bite occurring in or outside the boundaries of the base.

### AIM

3. Rabies is transmitted by infected saliva that enters the body through a bite wound or other open wound. The virus travels from the wound along nerve pathways to the brain, where it causes inflammation (irritation and swelling with presence of extra immune cells) that result in the symptoms of the disease. The incubation period ranges from 19 days to 7 years, with the average being 3 to 7 weeks. In the past, human cases have usually been a result of dog bites, but recently, more cases of human rabies have been linked to bats.
4. The purpose of this FSOP is to manage suspected animal bites and thereby prevent the possible transmission of rabies from animal to person.

### EXECUTION

5. In the event that a person requires medical treatment for an animal bite, the Preventive Medicine (PMed) section, will be informed and medical care will be received by the appropriate medical personnel. A PMed Report Re: Contact with a Suspected Animal (Tab A) will be completed with as much information as possible.
6. The PMed Department shall then proceed with an investigation of the incident including the following:
  - a. The victim will be contacted and interviewed on the details of the incident (at this time any info that is missing from the Contact with Suspected Animal Report will be completed); and

- b. Based on the results of the investigation and the veterinarian's findings, the medical authority will determine whether the animal will then be placed into quarantine or destroyed.

7. In the case where the animal is unable to be quarantined, (i.e. stray), rabies post exposure prophylaxis must be considered in every incident in which potential exposure to the rabies virus has occurred, unless rabies is known to be absent from the animal population. Rabies is endemic to Kandahar and surrounding areas. Post-exposure prophylaxis should start as soon as possible after exposure and should be offered to exposed persons regardless of the elapsed interval. Post exposure prophylaxis may start as late as six or more months after exposure. Vaccine should be administered in conjunction with RIG (Rabies Immune Globulin), or other clinical protocols as directed by the TF Surgeon.

### RESPONSIBILITIES

8. The Task Force Surgeon (through the Preventive Medicine Section), is responsible for:

- a. Contacting and interviewing the victim;
- b. Quarantine or killing of the animal if required; and
- c. Completion of the Contact Report.

9. MMU staff is responsible for completing the top portion of the PMed Report Contact with Suspected Animal (Annex A) and return to PMed.

10. The Immunization Clinic is responsible for holding the RIG and Rabies Vaccine (HDCV). They are also responsible for immunizing the victim.

11. This policy is subject to review and change as required conforming to current medical practices.

PMed Report of Contact with suspicious Animal, see Tab A

OPI: Preventive Medicine Section MMU  
Effective: 22 May 09

**Tab A - PMed Report of Contact with Suspicious Animal**

Part 1:

Medical Unit Reporting:				
Patient Information:				
	<i>Svc #</i>	<i>Rank</i>	<i>Surname</i>	<i>First name</i>
	<i>Home Unit</i>	<i>Age</i>	<i>Sex</i>	<i>Tel #</i>
Medical Officer:				
	<i>Name</i>		<i>Tel #</i>	
Date & Time of incident:				
Nature of injury:				

Part 2:

Animal:				
	<i>Species of animal</i>	<i>Description</i>	<i>Colour</i>	<i>Age</i>
Vaccination:				
	<i>Yes</i>	<i>No</i>		
	<i>Rabies shot</i>	<i>If yes, indicate date</i>	<i>Name, location of Vet</i>	
Animal at time of incident:				
	<i>Provoked</i>		<i>Unprovoked</i>	
Signature of Medical authority:				

Part 3: To be filled in by Preventive Medicine:

Animal Status			
	<i>Quarantined</i>	<i>Destroyed</i>	<i>Date &amp; Location</i>
Observation Report:			
Date of Investigation:			
Animal release date if quarantined:			
Patient Vaccination status:			
Inspectors' name:			
Signature			

<p style="text-align: center;"><b>APPENDIX 16 TO ANNEX D</b> <b>USOP 1600-1: EMERGENCY RECALL DRIVING PROCEDURES</b></p>
--

PURPOSE

1. The purpose of this USOP is to outline the procedure that MMU personnel will employ when responding to a medical emergency/major medical incident response. The procedures outlined in this USOP are a guide and in no way remove the burden of responsibility and liability for accidents caused by the unsafe operation of motor vehicles.

POLICY AND PROCEDURES

2. The MMU hospital periodically required to initiate a recall of its personnel to respond to a major incident, or other life threatening medical response. The following procedures will be used by MMU drivers to facilitate timely response while mitigating the risk of a traffic accident:

- a. MMU vehicles will be equipped with a placard indicating the vehicle in question is a MMF duty vehicle;
- b. Hazard lights (4 ways flashers) will be engaged on the vehicles;
- c. Where feasible, use of the horn to clear traffic is encouraged;
- d. Speed limits may be exceeded (to a limited extent) depending on road, dust, and traffic conditions;
- e. Vehicles may proceed through the fire lanes in Mod housing to pick up personnel in the most efficient manner; and
- f. In the future, it is planned to issue duty vehicle with emergency light to better identify them when responding to emergencies.

3. If the MPs observe a hospital duty vehicle during the course of this type of response they will provide as much assistance as possible (traffic control/escort) to ensure that they get where they need to be.

4. MMU personnel have been advised that these procedures are only to be employed during situations, where response time is critical, when proper risk management dictates, and when traffic and road conditions deem it safe to do so.

OPI: Deputy Commanding Officer Role 3

Effective:

Revise:

**INTENTIONALLY BLANK**

<p style="text-align: center;"><b>APPENDIX 17 TO ANNEX D USOP 1900-1: INTERPRETERS</b></p>
--

PURPOSE

1. The purpose of this USOP is to outline the policies and procedures for access to interpreter services for the MMU.

BACKGROUND

2. Interpreter services are used at the MMU to facilitate communications between staff and patients. The services of an LN interpreter are available in the MMF 24-hours a day through In-Patient Services.

POLICY AND PROCEDURES

3. Administration. OIC In-Patient Services is responsible to verify that the interpretation services were available during the times indicated on the interpreter sign-in sheet.

4. Security. Interpreters only have an enhanced reliability check and consequently they are not repeat not authorized access to any designated or classified material. Interpreters are not authorized access to the Tactical Operations Center (TOC), they are not authorized to use phones for personal calls, and they are not allowed to carry/use personal cell phones while on base however they have a designated cell phone kept on the ward which is used only for IPS needs. Any suspicious activity is to be reported to the unit security officer, the Adjt, or the DCO.

5. Protection of Interpreters. Interpreters are given an alias in order to protect their identity. There will be no photographs taken of interpreters without their prior written consent.

6. Interpreter Services for Detainees. As soon as the TOC is informed detainees will be brought to the MMF for an examination or medical treatment, the TOC Duty Officer will confirm all IMS at the MMF have been briefed on the timings and the area of the MMF that will be occupied by the detainee(s).

7. Interpreters Providing Services in the Presence of a Detainee. In the event that no Military Police interpreter is available when bringing in detainee, the MMF interpreters will be provided with sunglasses, masks, hats, and gowns when they are required to interpret between staff and detainees. All MMF staff are to take measures to protect the identity of all interpreters. When interpreters are required to translate for detainees, a screen will be placed so as to conceal the identity of the interpreter. It is preferable to have the MPs bring their own interpreter in these cases. MMF Interpreters are only to be used for medical purposes and not to be used for questioning.

8. Tasks. The responsibilities of the translators are to relay information accurately regardless of the operation (MASCAL, patient admission, etc.).

OPI: OIC In-Patient Services  
Effective:



<p style="text-align: center;"><b>APPENDIX 18 TO ANNEX D USOP 2000-1: DETAINEE OPERATIONS</b></p>
---

### PURPOSE

1. The purpose of this USOP is to outline the procedures to be used for the provision of medical support to detainees.

### BACKGROUND

2. Detainees are persons who are in the temporary custody of Coalition Forces pending transfer to HN National Security Forces (HN NSF). Detainees are to be treated humanely in accordance with the standards set in the Third Geneva Convention of 1949 as a PW until such time their status is determined.

3. It is important that detainees are examined by a medical authority to determine if there are any injuries

4. Suspected Abuse. All military and civilian personnel assigned shall report any suspicious circumstances, injuries or incidents through their chain of command.

5. Disclosure of Medical Information. See Tab A.

### GLOSSARY/DEFINITIONS/TERMINOLOGY

6. The following terms and their definitions are explained in order to facilitate the understanding of the medical procedures of a Detainee situation:

- a. Detainee. Detainees are persons who are in the temporary custody of Coalition Forces pending transfer to HN NSF; and
- b. Medical Examination. For the purposes of this SOP, a medical examination is a physical examination that evaluates and documents medical injury, trauma, or findings and reviews a victim's overall health. It includes the documentation of findings and may include photographs or radiographs as needed for patient care purposes only.

### POLICY AND PROCEDURES

7. General. It is important that all patients admitted or treated by the MMU, in any capacity, be treated with dignity and respect. Detainees are to be given access to the same level of health care as Coalition Forces. Respect for their dignity and their privacy will be observed. Their medical documentation shall be treated the same, so as to protect patient confidentiality. The MMU will not conduct outpatient services for detainees located at the internment facility. If detainees are brought wounded to the facility, necessary medical treatment will be provided in accordance with applicable clinical protocols. Once stable enough to move, the detainee patient will be transferred to the internment facility of the detaining Coalition force.

8. Concept of Operations. Once it has been identified that a detainee will be brought to the facility, the procedures and tasks outlined below will be followed.

Detainee ops will have a structured approach with the following phases or procedures:

- a. Phase 1 - Warning. Once the TOC has been warned that a detainee is in route to the facility, the duty officer will immediately alert the charge nurse, duty Medical Officer (MO) and key staff. The TOC will query the sending unit or internment facility staff as to the nature of the illness or wounding and estimated time of arrival at the facility. While being queried, the ward staff will conduct a quick bed survey to determine the most appropriate bed to locate the detainee, preferably isolated. The bed will be prepared IAW established ward SOPs and be physically separated from the other patients by a barrier or wall. The interpreter(s) will be informed that a detainee is in route so that they can protect their identities if required;
- b. Phase 2 - Arrival. Upon arrival, the staff will ensure that a guard remains while treatment is rendered. Ear Defenders and blindfolds will be utilized if not already on the patient. They may be used in the resuscitation area in order to protect the identities of trusted agents, interpreters and staff. If the sending unit or internment facility refuses to detail a guard, the TOC will be notified and they will immediately contact the MPs to attend. Until the MPs arrive, facility personnel will be designated to guard the detainee until relieved. When a patient is brought to us for care we will:
  - (1) Ensure that we document the assessment of the detainee's condition upon arrival to include the taking of digital photographs by Military Police;
  - (2) Inform Med Ops staff and MPs;
  - (3) Ensure that a physical barrier such as sheets, dividers or a wall is used to protect the identity of the staff/trusted agents and to maintain OPSEC of the facility. If being moved about the facility, the patient will be blindfolded and ear defenders put on him/her if possible while out of the isolated area. The guard will accompany the patient wherever they are transferred in the facility;
  - (4) Maintain detailed patient records regarding the detainee when in our care including the documenting of condition by digital camera;
  - (5) Track vital stats such as weight and medications while in our care;
  - (6) Will not divulge patient information unless ordered to do so;
  - (7) Respect cultural considerations as much as we can; Use restraints if required but only to protect the patient's well-being or for force protection;

- (8) Not provide info to interrogators or allow interrogations to be conducted on the ward;
  - (9) Protect the identity of local nationals in our employ; and
  - (10) Treat detainees as much as possible like any other patient.
- c. Phase 3 - Release. The MMU will track the patient's condition in detail until released from our facility. A copy of the patient records will be held in the facility while the original patient records will be forwarded to the receiving physician.
9. Grouping and Tasks:
- a. HQ/TOC.  
Phases 1-3 (Warning, Arrival, and Release).
    - (1) Provide coordination with MPs, escorting unit and all outside agencies as required;
    - (2) Provide a SITREP to RC Med Ops;
    - (3) Provide digital cameras to Med Staff if required; and
    - (4) Ensure that force protection measures are instituted and followed.
  - b. TREATMENT/WARD.  
Phase 1 (Warning).
    - (1) Conduct bed status upon warning that detainee will be attending the facility;
    - (2) Remove all rank badges and name tags of personnel detailed to provide treatment to the detainee;
    - (3) Secure all weapons that may be within reach of the detainee during treatment;
    - (4) Provide barriers to isolate the detainee if held on ward or locate them in the isolation ward if empty; and
    - (5) Warn local nationals in our employ that a detainee will be brought into the facility and protect their identity if required.

Phase 2 –3 (Arrival, Release).

- (1) Conduct examination of detainee IAW applicable clinical guidelines and protocols and record them as appropriate;
- (2) Document any signs of abuse and report this through the chain of command;
- (3) Ensure that a guard remains with the detainee at all times;
- (4) Secure personal weapons when treating the patient;
- (5) Maintain detailed records regarding the detainee when in our care;
- (6) Track vital stats such as weight and medications while in our care; and
- (7) Do not divulge patient information unless legally ordered to do so;

10. Coord Instructions.

- a. Alarms. All staff will remain vigilant when detainees are on the ward or in the facility. Guards will be present at all times during treatment.
- b. Code of Conduct. Attached as Tab B is the Code of Conduct that will be observed by all personnel have interaction with a detainee patient.

Enclosures:

Disclosure of Medical Information, see Tab A  
Code of Conduct, see Tab B  
Medical Certification, see Tab C  
Pre- and Post-Detention Medical, see Tab D  
Detainee Certification of Medical Examination, see Tab E  
Detainee Record of Medical Examination, see Tab F  
OPI: 2IC In Patient Services  
Effective:  
Revised:

**Tab A - Disclosure of Medical Information**

1. Whenever patient-specific medical information concerning detainees is disclosed for purposes other than treatment, health care personnel shall record the details of such disclosure, including the specific information disclosed, the person to whom it was disclosed, the purpose of the disclosure, and the name of the medical unit commander (or other designated senior medical activity officer) approving the disclosure.
2. The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential information without the express consent of the patient, unless required to do so by law.
3. Because the chain of command is ultimately responsible for the care and treatment of detainees, the internment facility chain of command requires some medical information. For example, detainees suspected of having infectious diseases such as tuberculosis (TB) should be separated from other detainees. Guards, health care workers and other personnel who come into contact with such patients should be informed about their health risks and how to mitigate those risks. Releasable medical information on detainees includes that which is necessary to supervise the general state of health, nutrition, and cleanliness of detainees, and to detect contagious diseases. Such information should be used to provide health care; to ensure health and safety of detainees, soldiers, employees, or others at the facility; to ensure law enforcement on the premises; and ensure the administration and maintenance of the safety, security, and good order of the facility.
4. Medical personnel, Patient Administration Staff, ICRC, and Service Investigators have access to med records if required. Military Police personnel or Detention facility personnel do not have access to med records and these cannot be used during interrogation.

**Tab B - Code of Conduct**

**1. MMU pers will not:**

- a. Fraternize with or act with undue familiarity towards a detainee, a former detainee, or a family member of a detainee or former detainee. Any contact or communication (oral or written, direct or mediated) between a health care worker and a detainee will be for an official purpose only;
- b. Engage in any act or attempt to engage in any act of sexual misconduct with a detainee, former detainee, or family member of a detainee or former detainee;
- c. Engage in any act or attempt to engage in any act of sexual abuse, assault, harassment of a detainee;
- d. Knowingly allow a detainee to engage in sexual misconduct with another detainee;
- e. Visit or enter the personal space of a detainee, former detainee, or family member of a detainee or former detainee except in the performance of official duties;
- f. Health care personnel are reminded that MP personnel have primary responsibility for security, custody, and control; and
- g. Place hands on or touch a detainee except in self-defense or to:
  - (1) Prevent escape;
  - (2) Prevent injury to persons or damage to property;
  - (3) Render medical assistance;
  - (4) Conduct a search or inspection;
  - (5) Apply the priorities of force, as specified in ROE; or
  - (6) Demonstrate *how-to* procedures in training.

**Tab C - Medical Certification**

1. I, \_\_\_\_\_ (Service Number) \_\_\_\_\_ (Rank) \_\_\_\_\_ (Name)  
have examined the following person (Name) \_\_\_\_\_ on this date \_\_\_\_\_ at  
the Multinational Medical Unit located at \_\_\_\_\_  
and found the individual fit / unfit for confinement.

2. The following represent any significant findings upon examination:

Signature

\_\_\_\_\_

**Tab D - Pre- and Post-Detention Medical**

**INTRODUCTION**

1. This annex provides guidance on the pre- and post-detention physicals for detainees at the Role 3 Multinational Medical Unit (MMU). All detainees held are screened both on arrival and departure when operationally feasible. This medical visit has three goals:

- a. Document the detainee's physical condition at the time of the exam;
- b. Establish current or chronic medical conditions that require treatment while in detention;
- c. Provide medications, medical supplies and written instructions as required to the Military Police for the detainee's medical care while in detention.

2. All detainees are to be treated fairly and humanely IAW international law and National/NATO doctrine. This includes medical care equivalent to that expected for national or other coalition members. The priority for those requiring management is based exclusively on medical criteria.

**PROCEDURE**

3. The MPs initiate this procedure by arranging timing of exams with the MMU TOC or Primary Care. Clearly, trauma patients or other urgent medical care activities take priority. In addition, prime sick parade hours of 0800-1100 hours are to be avoided when practical. The number of detainees in a given session may also be an issue as these physicals can be time consuming. The Military Police (MP) are encouraged to present with four or less detainees at any one time.

4. All detainees will be searched prior to entering the MMU and will be guarded at all times by the MPs. Medical staff will discuss only clinically related matters with the detainee. The procedure for the detainee medical is as follows:

- a. The MPs call the MMU Tactical Operations Centre (TOC) to request medical at a certain time and for a given number of detainees:
- b. The TOC informs Primary Care of the requirement for detainee physicals. Primary Care may negotiate directly with the MPs if the number of detainees or timing is an issue;
- c. Primary Care will prepare for the detainee medical. This includes setting up a screen in the back of primary care to shield the interpreter from view, borrowing an interpreter from the ward, assembling the physical exam instruments, and ensuring that a clinician (Medical Officer, Physician's Assistant of any nationality) is available or is recalled, if necessary, to do the history and physical;



- d. The MPs bring the detainee(s) to the backdoor of primary care (and let the Medical Technicians know they have arrived. The detainee is usually bound at the wrists and wearing ear defenders and eye coverings. These items are removed as needed during the exam by the MPs;
- e. The Primary Care Med Techs will measure the detainee's vitals (weight, blood pressure, heart rate, temperature and oxygen saturation, and possibly visual acuity if this seems to be an issue);
- f. The clinician then performs a history to include current complaints, past medical history, allergy, medications, review of systems and brief mental health screen;
- g. The clinician then performs a physical exam. This exam will establish any existing trauma or injuries, or any other medical condition(s);
- h. When the medical is complete the detainee has restraints replaced and is removed from the facility by the MPs;
- i. The clinician completes the two detainee forms (see below), and prescriptions, etc. as needed. Care needed while under detention may be discussed with the MPs as needed; and
- j. Alternatively, (this being the preferred option) exams may take place in the detention facility when appropriate. The facility has equipment necessary to conduct thorough medicals is in place. The MPs will provide security and translators in this case.

#### DOCUMENTATION

5. The clinician fully documents the history and physical on the Detainee Record of Examination (Tab F). The original will be retained national policies, and a copy will be passed to the MPs in a sealed envelope. A companion form, the Certificate of Examination (Tab E), does not include the medical information beyond what the MPs or others managing the detainee need to know during the detention. This form certifies that the medical exam has been done, that the detainee is fit for detention, and summarizes medications or medical treatments that are needed while the individual is in detention.

6. If any injuries or trauma are discovered these are fully documented in the Record of Examination. The MP responsible for the detainee is notified. Medical staff may take a photographic record the injuries; photos will also be taken by the MPs.

#### OTHER ISSUES

7. If the detainee is not fit for detention then the individual will be treated or admitted to the hospital for care as required.

**Tab E - Detainee Certification of Medical Examination**

**DETAINEE CERTIFICATE OF MEDICAL EXAMINATION**

DETAINEE NUMBER - NOMBRE DE DÉTENU		DATE	MP ESCORT – ESCORTE MP	
DETAINEE SURNAME – NOM		GIVEN NAME – PRÉNOM	CLINICIAN RESPONSIBLE NAME - NOM DE CLINICIEN RESPONSABLE	
AGE/DOB – /DDN	GENDER – GENRE	EXAMINATION UNIT – ÉTABLISSEMENT MÉDICAL		CLINICIAN'S RANK - GRADE DE CLINICIEN RESPONSABLE
<p>The above individual was examined on (date and time) _____ at (location) _____ located at (physical location) _____.</p> <p>The details of the examination are recorded on the medical examination record held in the medical file. The individual is uninjured/injured and is fit/unfit for detention, or fit/unfit for interrogation.</p>		<p>L'individu ci-dessus a été examiné le (date et d'heure) _____ à (endroit) _____ située (endroit physique) _____.</p> <p>Les détails de cet examen sont enregistrés sur la Fiche d'examen Medical tenu dans le dossier médical. L'individu est n'est pas blessé/blessé, est fit/unfit pour la détention, et/ou est fit/unfit pour interrogation</p>		
PLACE OF DETENTION – ENDROIT DE DETENTION		EXAMINATION LOCATION – ENDROIT D'EXAMEN		
INFORMATION ON INJURY, ILLNESS OR SIGNIFICANT FINDING AS APPLICABLE - L'INFORMATION SUR DES BLESSURES, LA MALADIE OU LA CONCLUSION SIGNIFICATIVE COMME APPLICABLE				

The individual will require the following medications or medical treatments while in detention:

L'individu aura besoin des traitements suivants de médicaments ou médical lors de sa détention:

**Tab F - Detainee Record of Medical Examination**

**DETAINEE RECORD OF MEDICAL EXAMINATION - FICHE D'EXAMEN MÉDICAL**

DETAINEE NUMBER - NOMBRE DE DÉTENU		DATE	MP ESCORT		
DETAINEE SURNAME – NOM		GIVEN NAME – PRÉNOM	EXAMINATION LOCATION - ENDROIT D'EXAMEN		
AGE/DOB – /DDN	GENDER – GENRE		EXAMINATION UNIT – ÉTABLISSEMENT MÉDICAL	EXAMINER'S RANK - GRADE DE L'EXAMINATEUR	
PLACE OF DETENTION - ENDROIT DE DÉTENTION			EXAMINER'S NAME - NOM DE L'EXAMINATEUR		
HEIGHT - TAILLE (cm)	WEIGHT - POIDS (kg)	PULSE - POULS	VISION – ACUITÉ VISUELLE (IF NEEDED)	R - D	L - G
BLOOD PRESSURE - S D PRESSION ARTÉRIELLE			UNCORRECTED – SANS LUNETTES	6/	6/
TEMP	RESPIRATION	O <sub>2</sub> SAT	CORRECTED – AVEC LUNETTES	6/	6/
SCARS - BIRTHMARKS - TATTOOS (VISIBLE) CICATRICE - TACHE DE NAISSANCE - TATOUAGES (VISIBLE)					
<p>HISTORY AND/OR FINDINGS PERTINENT TO EXAMINATION – ANTÉCÉDENTS MÉDICAUX ET/OU OBSERVATIONS PERTINENTES À L'EXAMEN MÉDICAL</p> <p style="text-align: right;">CC HPI PMHx/SHx FHx MEDICATIONS ALLERGY - ALLERGIE OTHER DRUGS – AUTRES DROUGUES IMMUNIZATION</p>					
DATE	SIGNATURE - SIGNATURE		MEDICAL CERTIFICATION FORM TO MPs YES/OUI NO/NON		

**ANNEX D TO  
AMedP-9.2**

DETAINEE NUMBER - NOMBRE DE DÉTENU		DETAINEE SURNAME – NOM	GIVEN NAME – PRÉNOM	DATE
PHYSICAL – EXAMEN PHYSIQUE				
EYES/FUNDI - FOND D'OEIL				
EARS - OREILLES				
NOSE - NEZ				
MOUTH AND TEETH - BOUCHE ET DENTS				
HEAD AND NECK - TÊTE ET COU				
THORAX				
LUNGS - POUMONS				
HEART - COEUR				
ABDOMEN				
SPINE - COLONNE VERTÉBRALE				
SKIN - PEAU				
EXTREMITIES - MEMBRES	UPPER - SUPÉRIEURS			
	LOWER - INFÉRIEURS			
NEUROLOGIC EXAM - EXAMEN NEUROLOGIQUE				
PSYCHIATRIC EXAM - EXAMEN PSYCHIATRIQUE				
GYNE/GU – AS NEEDED				

**ANNEX D TO  
AMedP-9.2**

INJURY - BLESSURES			FINDINGS - RESULTATS
INVESTIGATIONS - PROCEDURE	YES OUI	NO NON	
URINALYSIS - ANALYSE D'URINE			
BIOCHEMISTRY - BIOCHIMIE			
HEMATOLOGY - HÉMATOLOGIE			
CHEST X-RAY - RADIOGRAPHIE PULMONAIRE			
OTHER - AUTRE			
EXAMINING PHYSICIAN'S COMMENTS – REMARQUES DU MÉDECIN EXAMINATEUR			

DATE	SIGNATURE - SIGNATURE	MEDICAL CERTIFICATION FORM TO MPs YES/OUI	NO/NON
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<p style="text-align: center;"><b>APPENDIX 19 TO ANNEX D USOP 2100-1: DENTAL SECTION</b></p>
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PURPOSE

1. The purpose of this USOP is to outline the operations of the Dental Section at the Multinational Medical Unit (MMU) Hospital located at.

GLOSSARY/DEFINITIONS/TERMINOLOGY

2. The following terms and their definitions are explained in order to facilitate the understanding of the remainder of USOP 2100-1:

- a. Multinational Medical Unit (MMU). Refers to the Role 3 hospital including all its departments and infrastructure. The Dental Section is one of its units and is found at the main entrance to the MMF Hospital;
- b. Force ( \_\_\_\_\_ ). Refers to those countries whose military is currently serving in \_\_\_\_\_ and are stationed at.
- c. Oral Maxillofacial Surgeon (OMFS). Specialist (dentist) licensed in accordance with his national legislation to perform surgery in the oro-maxillofacial area who is a MMU Hospital asset and is available for consultations and referrals as required by the MMU Dental Section.
- d. Dental Officer (DO). Person licensed in accordance with his national legislation to perform dental care or/and dental surgery.
- e. Duty Officer. A duty officer is available 24/7 via the Tactical Operations Centre (TOC), and is the means by which the duty dental team can be contacted outside of normal working hours for consultations and dental emergencies.

MISSION

3. To ensure that dental conditions do not impact operations or prevent individuals from completing required tasks in current area of operations (AO) and to reduce the number of dental emergencies in the field to the lowest level possible.

ROLE AND ORGANIZATION

4. The primary role of the MMU Dental Section is to provide dental support as necessary to all authorized and entitled military personnel. The goal is to assist and maintain an operational state of dental readiness for all personnel. The Dental Section capabilities consist of Role 1, 2 and limited Role 3 including minor maxillofacial surgery. Full OMFS capability is available as required through the MMU.

5. The MMU Dental Section is set up according to the minimum requirements of AMedP-1.17 as follows:

<u>Capability</u>	<u>Dental personnel</u>	<u>Assistants required</u>
Provide first aid	All DP	
Provide emergency dental care	DO OS	advised
Provide pain relief in oro-facial region	DO OS	advised
Provide primary dental care	DO OS	Yes
Provide intraoral radiography and diagnosis	DO OS	advised
Provide dental- alveolar Surgery	DO OS OMFS	Yes
Provide secondary dental care	DO OS	Yes
Provide panoramic radiography and diagnosis	DO OS OMFS	advised
Provide oro- maxillofacial surgery	OMFS OS	Yes
Forensic odontology	DO OS OMFS	advised

6. The MMU Dental Section is under the direct command and control of the MMU Officer Commanding (OC). The Dental Section DO's are the responsible dental technical and professional advisors to the senior officer exercising the function of command or executive authority on all matters pertaining to the dental health of all personnel under his jurisdiction.

#### DUTIES AND RESPONSIBILITIES

7. The MMU Dental Section is responsible for:
- a. Maintaining oral health and prevent progression of dental diseases;
  - b. Providing emergency, primary dental care, secondary dental care, dental alveolar surgery care and oral-maxillofacial (OMF) surgery treatment;
  - c. Preparing dental patient documents, maintain statistics, and submit reports and returns as requested and required by the chain of command (CoC);



- d. Receiving and control dental equipment, material and consumables;
- e. Ensuring proper care and maintenance of dental equipment, with appropriate records for servicing and repair;
- f. Providing para-medical (first aid) support in the event of an incident such as Mass Casualty (MASCAL) or as directed by the MMU OC and following core skills: emergency dental care, pain relief in oro-maxillofacial regions, primary dental care, contributing intra-oral and panoramic radiography applied to national laws, dental-alveolar surgery, secondary dental care, oro-maxillofacial surgery and forensic dentistry; and
- g. Fulfilling other duties and responsibilities as required or assigned by MMU OC.

## POLICY AND PROCEDURES

### General

8. All personnel (military and civilian) should be screened by a dentist and deemed “dentally fit” according to the AMedP 4.4 for the expected duration of the deployed “in theatre” period. The number of dental emergencies in the field should be reduced to the lowest level possible. If this period is in excess of 12 months, the screening dental authority should be proactive in providing all treatments of a preventative nature to deploying personnel. Routine dental examinations, preventive measures and treatment programs can reduce the risk of personnel experiencing dental disorders during deployment.

9. Personnel who arrive in theatre with “high risk” dental treatments outstanding and present at the MMU Dental Section in dental pain may be classified as a “dental casualty”. If the required dental treatments to make the individual dentally fit could not be provided by the MMU dental section, the individual may be repatriated to country of origin on the recommendation of the attending DO and at the discretion of OC In-Patient Services.

10. All personnel should be made aware of the availability of emergency dental services at MMU Dental Section at the site specific “Arrivals Brief”. This will include organization matters/issues like details on location, hours of operation including sick parade/walk-in emergency clinic hours and after-hours emergency protocol. Personnel with dental pain are encouraged to contact or visit the MMU Dental Section at the earliest opportunity.

### Treatment Protocols

11. All dental casualties, regardless of nationality or status will be triaged based upon the seriousness of their dental condition. Patients in severe dental pain will receive immediate dental therapy to relieve pain and regain dental fitness.

12. Sick parade/Walk-in Emergency Clinic will be run on a first come, first serve basis. Military personnel, particularly those who are at the MMU from remote locations and for a

limited time, will be given priority regardless of time of arrival or sign up order. The previous USOP (12) will override this if another patient requires immediate dental interventions.

13. Maxillo-facial patients will be classified as medical patients, and after consultation with the OMFS, they will be referred as required.

14. All entitled personnel (military and civilian) will be provided equal access to dental care as resources and circumstances permit.

### SUPPLY PROCEDURES

15. The MMU Dental Section will be stocked with a 30 to 60 day consumable load at all times. All dental bulk stores will be stored in the Dental section supply room.

16. Each countries dental team is responsible for utilizing that countries Supply system for ordering and re-supply of dental consumables. The dental teams will coordinate and cross-reference on orders to minimize waste and excessive stock of similar supplies.

17. Requests for new equipment or replacement of obsolete equipment will similarly be forward through the appropriate channels as per individual dental team protocols.

### EQUIPMENT AND MAINTENANCE

#### Inventory/Distribution Account

18. All items that are accountable are to be detailed within an inventory or distribution account (DA). This inventory is to be verified and updated every handover to new dental teams. It is the responsibility of the incoming DO, who is the DA holder, to ensure the accuracy of the inventory and to correct deficiencies or inaccuracies.

#### Maintenance

19. User maintenance and first line repair of dental equipment is the responsibility of the dental assistant / technical personnel of the MMU Dental section.

20. The dental assistant / technical personnel will carry out daily, weekly and monthly checks and maintenance of equipment IAW manufacturers' instructions and MMU Dental section maintenance protocols according to national legislation

### SERVICING AND RETURN

21. MMU Biomedical Engineering Technician (BMET) /MDSS section is the repair or servicing authority for dental equipment.

22. Return or disposal of dental equipment will be carried out IAW with individual dental teams' protocols and inventory /DA's will be updated accordingly.

### PATIENT CARE AND TREATMENT

23. Personnel requiring dental treatment are to contact or report to the MMU Dental section at the earliest opportunity. Outside regular dental section working hours the patient will report to Primary Care/Sick Call reception.
24. Prior to consultation with a DO, all patients are to complete a "Patient Medical History".
25. The attending DO will make every effort to deliver immediate definitive therapy and, if possible, return the patient to an operational state of dental fitness at the same visit.
26. Patients with maxillo-facial trauma will be assessed by a DO and a consult and/or referral to the OMFS will be made as required.

### PATIENT RECORDS AND DOCUMENTATION

27. All military personnel's temporary dental document will be mailed to the members' home Dental Detachment or Dental Centre following their end of tour date. Documents will not be hand carried and no copies of these documents will remain in theatre. The disposition and retention of dental documents will be in accordance with applicable national laws.
28. All other foreign military and civilian temporary dental documents will be disposed of IAW the MMU Hospital Document Disposal Protocol.
29. Copies of the dental record can be made for individual patients when specifically requested.
30. All dental records will be stored appropriately within the MMU Dental Section with due regard for security and confidentiality.

### REPORTS AND RETURNS

31. The MMU Dental Section will complete and submit the following reports:
  - a. Weekly EpiNato statistics on patients seen and treatments delivered;
  - b. Monthly cost capturing data for treatments delivered to eligible civilians;
  - c. End of tour After Action Report (AAR) as outlined by individual dental teams protocols; and
  - d. Other reports and return as required or requested by individual dental teams CoC in accordance with national laws.
32. The DO's are responsible for providing development and evaluation reviews for the dental personnel IAW with individual military evaluation protocols.

HOURS OF OPERATION

33. The general hours of operation are 0800hr (3:30 Z) to 1600hr (11:30 Z) Sunday to Saturday, Emergency dental treatment coverage is provided 24/7.

34. Dental Sick Parade/Walk-in Emergency Clinic is from 0800hours (3:30 Z) to 1000hours (5:30 Z), all week long.

35. Dental appointments are scheduled Sunday through Saturday at 1000hours (5:30 Z) to 1600hours (11:30 Z), allotting one hour for lunch at 1200hours.

36. After hours, dental patients that present at the TOC should be sent to Primary Care for a medical assessment of their dental problem. If the Duty MO deems a dental consultation is required then the following may occur:

- a. The duty officer at the TOC is notified to contact the Duty DO; or
- b. The Duty MO can contact the Duty DO directly at cell phone.

37. This consultation will determine if the Dental personnel will be paged at \_to prepare the dental operatory for the patient.

OPI: OC Dental Section  
Effective:  
Revised:

<p style="text-align: center;"><b>APPENDIX 20 TO ANNEX D</b> <b>USOP 2400-1: PHYSIOTHERAPY DEPARTMENT SERVICES</b></p>
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1. The purpose of this USOP is to promulgate HSS policy and Procedures pertaining to the concepts of physical therapy services provided to Coalition personnel, Allied forces, and other eligible non-military contractual pers in the Area of Responsibility (AOR).

ROLE AND RESPONSIBILITY

2. Composition. The Physiotherapy Section consists of a Physiotherapy Officer (PTO) and a Medical Technician Physiotherapy Assistant (PTA). The Physiotherapy Section has equipment typical of a small outpatient clinic. The PTA provides direct patient care under the direction of the PTO, which includes fitting supportive devices, maintaining stock, and clerical support including the collection of statistics.

3. Primary Care Outpatients:

- a. Perform physical assessments in order to develop clinical diagnoses and treatment plans for a variety of MSK, cardio respiratory and neurological conditions, which may include recommendations for further investigation, restricted\modified duties, etc.;
- b. Provide input regarding expected recovery times and prognosis for enhanced decision making and patient management;
- c. Provide early intervention in the form of education, exercises, manual and pain modulating therapies;
- d. Provide physiotherapy interventions that will help achieve patient and therapist established functional discharge criteria. This may include education, therapeutic exercises, soft tissue and manual therapy techniques, and the use of physical, electrotherapeutic and mechanical agent;
- e. Fitting and educating patients with regard to the use of gait aids, orthotics, and a variety of braces and protective devices;
- f. Promote continued fitness and assist with the creation of safe and healthy exercise programs for future injury prevention, and to return those with recovering injuries to full operational status; and
- g. Educate other health professionals on physical therapy\MSK management and our approach to MSK, cardio respiratory and neurological assessment and treatment.

4. MMF Inpatients:

- a. Perform physical assessments in order to develop clinical diagnoses and treatment plans for a variety of MSK, cardio respiratory and neurological

conditions including post-op;

- b. Provide early, rapid evaluation and treatment of allied inpatient troops in order to ensure ongoing availability of ICU and ward beds. This may include a variety of cardio respiratory techniques, functional splinting or safe early mobilization and ambulation; and
- c. Provide input regarding expected recovery times and prognosis for enhanced decision making and patient management.

### HOURS OF OPERATION

5. Physiotherapy services will be accessible seven days a week:
  - a. Monday to Saturday: 0800-1600;
  - b. Clinic closed for lunch 1200-1300;
  - c. Sunday: 1300-1600 by appointment only; and
  - d. This schedule is flexible to accommodate any increase in caseload. The PTO will carry a pager and can be reached at any time for emergencies at #.

### ACCESS TO PHYSICAL THERAPY

6. The privileged point of access will be the outpatient dept for registration purposes and to initiate the chart. However, patients will access physiotherapy via a number of different routes. These include referral by: self, workplace, health professionals including Medical Officer, Medical Doctor (civilian), Physician Assistant, and other health care providers. Only referrals coming from the health care providers will be processed as new patients. Others may be seen as “drop-in patients”, where no paperwork will be initiated. If a “drop-in patient” is deemed appropriate for active physiotherapy treatment and follow-up, they will be sent back to their provider in order to get a physiotherapy consultation form completed to start their active physiotherapy file. If they come in only for advice or fitting of a brace, no file will be processed.

### PROCEDURE FOR PATIENT CARE

7. Outpatient Physiotherapy. Patients will be referred to the Physio department as above. New assessments will be scheduled according to priority requirements. Follow-up appointments for ongoing physical therapy interventions will be booked as needed in order to achieve discharge criteria established in conjunction with the patient at the initial assessment. A discharge note and record of services provided will be added to the medical file.

8. Inpatient Physiotherapy. Inpatients will be treated from 0845 to 0930, (i.e. after patient rounds) or whenever a patient’s status necessitates or other opportunity arises. These treatments will be performed by the PTO or the PTA under the supervision of the

PTO. In addition to the referral points indicated above, patient rounds (0830 hours) will provide an opportunity for the PTO to identify patients that will benefit from Physio intervention. Physiotherapy staff will attempt to take a proactive role in positioning, splinting, early safe ambulation and chest care in order to facilitate rapid transition from the ICU to the ward to discharge. Charting will adhere to CF guidelines above.

OPI: OIC Physiotherapy  
Effective:  
Revised:

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<p style="text-align: center;"><b>APPENDIX 21 TO ANNEX D USOP 2700-1: ALTERNATE SURGICAL SITE</b></p>
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PURPOSE

1. The Alternate Surgical Center (Alternate Site) is a contingent facility to provide very limited essential life/limb saving damage control surgery prior to evacuation of casualties to higher levels of care. The ASC would only be used in the event of a MASCAL situation on camp where the MMF is deemed non-functional (fire, bombing, or explosion). Given that scenario it has to be ready at any given moment and be operational in very short delay.

Applicability

2. To ALL operating room, transfer and postoperative care personnel.

STANDARD OPERATING PROCEDURES

3. Limitations: The Alternate site has the following limitations:

- a. Only one Operating table with limited capacity;
- b. Limited Anesthesia capability with only one Anesthesia machine;
- c. No bulk sterilization capability and only limited flash sterilization capability;
- d. Very limited Storage capacity for surgical trays and equipment;
- e. No surgical sinks or drains;
- f. Limited surgical lighting;
- g. Limited ventilation (A/C dependent); and
- h. Limited preoperative resuscitation capability.

4. Concept of Operations:

a. Activation

- (1) The MMU ASC will be ONLY activated in the event that the MMU main operating rooms are rendered inoperable AND casualties that required immediate life/limb saving surgeries prior to evacuation exist;
- (2) Activation decided by the Task Force Surgeon, in liaison with the Surgical Services Team and the RC Medical Director;

- (3) Activation will require a full OR team and take up to 45 minutes to fully activate; and
- (4) Full cooperation of the personnel at the alternate site will be required to rearrange the facility.

b. Anesthesia Services: The ASC will be able to provide:

- (1) Interim services only for critical surgical cases, routine services will be suspended pending return to a Role 3 level facility.
- (2) Limited holding capacity pre and postop;
- (3) Physiologic monitoring of ONE operative case including Arterial line and central venous monitoring at a time;
- (4) 12 hours of Medical Air and Medical Oxygen at 12L/min flow rates;
- (5) Intraoperative IV resuscitation of Crystalloid/Colloid to maximum of 24L (8L/case for 3 cases);
- (6) NO intrinsic Blood product transfusion capability;
- (7) Provide external re-warming using Beegle fluid warmer and Baer Hugger air warming blankets; and
- (8) Limited difficult airway capability to only include: LMA #4/#5, Trachlight, cricothyroidotomy.

c. Surgical Services: The ASC will be able to do the following:

- (1) ONE Open Laparotomy (DCS) to include:
  - (a) Bowel resection;
  - (b) Diverting colostomy;
  - (c) Emergency splenectomy;
  - (d) Abdominal packing;
  - (e) Ligation of iliac vessels and other intraabdominal bleeders;
  - (f) Temporary cross clamp of the aorta; and
- (g) Preparation of an open abdomen for evacuation.
- (2) ONE Open thoracotomy (DCS) to include:
  - (a) Chest tube placement (up to 4) including pleurevacs;

- (b) Left open thoracotomy;
  - (c) Clamshell thoracotomy;
  - (d) Sternotomy;
  - (e) Non-anatomical Wedge resection of the lung;
  - (f) Temporary ligation/control of the great vessels;
  - (g) Ligation of small vessel intrathoracic bleeders;
  - (h) Relief of pericardial tamponade;
  - (i) Repair of lacerated ventricle; and
  - (j) Reduction and temporary repair of diaphragmatic hernia.
- (3) One Emergency Orthopedic to include:
- (a) External fixation of the pelvis without x-ray;
  - (b) External fixation of two limbs without x-ray;
  - (c) Ligation of peripheral limb bleeders;
  - (d) Application of up to 4 CAT tourniquets for evacuation and;
  - (e) Have NO C-ARM or X-RAY capability.
- d. Preoperative resuscitation:
- (1) The ASC has NO capability of preoperative resuscitation, diagnosis, x-ray and;
  - (2) This is relegated to the MMU Resuscitation team and the to the alternate site resuscitation bay plan and beyond the capability and scope of the ASC.
- e. Post-Operative / Anesthetic Care:
- (1) The ASC has NO HOLDING capacity;
  - (2) The ASC can recover ONE post-operative/Anesthetic patient using its intrinsic Operating Room nursing staff to include physiologic monitoring for up to 4 hours or until transfer whichever is sooner;

- (3) The ASC will require supplemental nursing staff and equipment to recover any more than one post-operative/anesthetic patient or any time greater than 4 hours;
- (4) Postoperative supplemental oxygen of up to 24 hours with face mask or nasal prongs up to 10L/min; and
- (5) Postoperative ventilation of only ONE patient on TIVA and on the 754 ventilator. This may render the ASC inoperable.

5. Maintenance:

- a. The MMU Senior OR nurse checks medications on weekly bases and replaces expired items;
- b. The MMU OR team does weekly cleaning of the ASC;
- c. The MMU Senior OR Technician (ORT) ensures all routine maintenance and functioning of the OR equipment;
- d. The Senior ORT performs monthly checks of all sterilized equipment; and
- e. The Senior ORT verifies oxygen and air supply monthly.

OPI: Senior OR Nurse  
Effective:  
Revised:

<p style="text-align: center;"><b>APPENDIX 22 TO ANNEX D</b> <b>USOP 2700-2: ALTERNATE INTENSIVE CARE UNIT / INTENSIVE CARE WARD</b></p>
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PURPOSE

1. In the event that the MMU becomes non-operational, secondary to battle damage or fire, the requirement for provision of emergent, sustaining and initial surgery will remain unchanged. Consequently the need to deploy an alternate site ICU/ICW, in a limited time span, exists. Therefore, the alternate ICU/ICW will be a contingency facility to provide very limited Critical Care to acutely injured personnel prior to evacuation to higher levels of care.

APPLICABILITY

2. To all ICU/ICW staff, including Intensivists, General Duty Nursing Officers (GDNO) /Critical Care Nursing Officers (CCNO), Medical Technicians, and Specialists providing care for ICU/ICW patients.

STANDARD OPERATING PROCEDURES

3. Limitations: The alternate ICU/ICW have the following limitations:
- a. Reduced volume of service available;
  - b. Reduced space for casualty movement & service provision;
  - c. Reduced holding capacity;
  - d. Reduced capacity to provide advanced health services support, WRT availability/functioning of electromechanical equipment and consumable EIS (Equipment Issued to Scale) for such equipment;
  - e. Limited storage capacity for electromechanical equipment, consumables, medications & oxygen;
  - f. Increased demand on locally available electrical grid for electromechanical equipment employed within ICU/ICW;
  - g. Reduced capacity for transfusion of blood or blood products secondary to pending location of lab Svcs;
  - h. Limited access to sinks, drains & toilets;
  - i. Increased demand on locally available plumbing system;
  - j. Increased demand on pharmacy & FMED provision of services and consumable products secondary to minimal integral storage capacity;

- k. Increased staff to client ratio secondary to reduced space/holding capacity;  
and
- l. Reduced linen stores availability.

4. Concept of Operations:

a. Activation

- (1) The Alternate MMU will be activated in the event that the current facility is rendered inoperable;
- (2) Activation will remain the command responsibility of the Task Force Surgeon, in liaison with OC In Patient Services;
- (3) Activation will require staffing sufficient to man the bed numbers as outlined in groupings and tasks below;
- (4) Establishment of the Alt site ICU/ICW will be directed by the respective head of each section;
- (5) Equipment for the Alt MMU will be co-located at the alternate site prior to the deployment of said facility;
- (6) Equipment will be allocated on a per bed basis for the ICU, and shared equipment on a ratio per bed basis for the ICW;
- (7) Upon notification the alternate location will reconfigure per established plans; and
- (8) ICU will deploy 2 critical care beds & 2 trauma bays for the provision of emergent, post-op and intensive nursing care

b. ICU/ICW Maintenance:

- (1) ICU/ICW sections will ensure a 24hr supply of consumable items, held in reserve at the storage site, IAW current operational trends;
- (2) Maintenance of prepositioned electromechanical equipment, consumables and medications will be the responsibility of ICU/ICW sections; and
- (3) On site oxygen supplies will remain the responsibility of the ORT, IAW current practices.

c. Post-Operative/Anesthetic Care:

- (1) The ICU will continue to provide post-operative care to patients until stable for transfer to the ICW; and
- (2) Equipment including suction, oxygen, and emergency equipment will be maintained by the ICU section and ward master.

OPI: Wardmaster  
Effective:  
Revised:

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<p style="text-align: center;"><b>APPENDIX 23 TO ANNEX D</b> <b>USOP 2800-1: BIOHAZARD WASTE DISPOSAL (IN-PATIENT SERVICES)</b></p>
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Ref. USOP 1400-3

PURPOSE

1. To establish a procedure to appropriately dispose of all In Patient Services' biological waste in support of above references and to address aspects more specific to In Patient Services.

APPLICABILITY

2. All staff assigned to In Patient Services; namely the Trauma Bays, Ward, ICU, and Operating Room/Central Sterilization Room (CSR).

3. This is a section level SOP and must be followed in conjunction with the above USOP reference.

POLICY

4. All In Patient Services staff will be orientated to this SOP upon arrival.

5. Garbage bins with black bags are not to be kept in direct patient care areas but may be placed in general use areas such as: offices, reception areas, meeting areas (e.g., nurse's station, Medical Officer's room), and/or in areas approved by the CO;

6. Only red biohazard bins/boxes with appropriate biohazard bags (red or yellow) are to be kept in direct patient care areas (e.g., Trauma Bays, Primary Care, OR, ICU, ICW);

7. Biohazard bags are to be double bagged. Those requiring reinforcement are to be triple bagged with additional biohazard bags only. Black bags are not to be used;

8. Disposal of biohazard waste in the reefer will be placed in order-designated areas based on priority. OR/Trauma Bays (Priority 1) and ACW/ICU (Priority 2). Complete details reference storage of waste are IAW the above refs;

9. All biohazard **and** black garbage bags sent for disposal from MMF will be tagged with the following information displayed:

- a. Location (e.g., Resus);
- b. Date (e.g., 17 May 08); and
- c. Time (e.g., 1900L).

10. Ensuring proper disposal of all waste, including biohazard waste, will be the responsibility of the Duty Charge Nursing Officer and Senior Med Tech / Ward master;
11. MMU cleaners will only be responsible for disposal of black bag garbage and will tag garbage as per para 6; and
12. All personnel will be familiar with this SOP and above references.

OPI: Wardmaster

Effective:

Revised:

<p><b>APPENDIX 24 TO ANNEX D USOP 2800-2: DETAINEE CARE</b></p>
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PURPOSE

1. To provide a standardized approach regarding detainee care.

APPLICABILITY

2. All staff assigned to MMU In Patient Services.

POLICY

3. When Detainee(s) is/are admitted to our facility the security of the detainee is the primary responsibility of the Security Forces of the capturing nation. A guard will be from the same nation as the detaining nation 24/7, and if difficulties are encountered, the Charge or Head Nurse will coordinate with the TOC.

4. Detainee(s) will not cohabitate with other civilian, coalition or military populations. Ward status detainees will be segregated in a separate room (e.g., Isolation Room). Curtains will be drawn around the bed of ICU status detainees.

5. Detainees will have ear defenders, eye patches or a blindfold when moving about or transferred within the facility. This includes being moved from their room to the OR and/or to the latrine for a shower.

6. All staff entering the room will remove their weapon, nametags, rank, and service tape from their uniforms or simply remove your uniform jacket. First names only will be used to refer to staff members.

7. The detainee will not undergo extended sensory deprivation. Sensory deprivation is the use, unnecessary use or prolonged use of blindfolds or ear-defenders preventing sensory stimulation and resulting in minimal interaction with the environment. Therefore, blindfolds and ear defenders will be removed when detainee returned to their room.

8. At no time will the face of the interpreter come in to full view of the detainee. The interpreter will stand behind the curtain or outside the door to facilitate communication with the detainee. Interpreters may wear a mask, goggles and hat to cover their identity. The Charge Nurse is responsible to inform the interpreters when a detainee is in the facility.

9. It is the responsibility of the TOC to notify In Patient Services staff of changes in patient status from Detainee to Person of Interest to Local National. This will be communicated to all nursing personnel and the patient will immediately, if bed space available, be moved from secluded area to general patient population.

9. Detainees will NOT be interrogated, coerced, or threatened in our facility. Questioning or the conducting of interviews of detainees can only occur in our facility upon

approval of the CO or OC R3. Those personnel questioning or conducting interviews must use their OWN interpreters.

11. In the event of a MASCAL, the primary physician will determine if the detainee is stable enough to move to the detainee holding facility. If so, responsible security forces will make arrangements for transport.

12. In the event of a MASCAL and the primary physician determines the detainee is not stable enough to move to the detainee facility, security forces will continue to provide security for the patient. Nursing will continue care of the patient in the current location.

13. At no time will ICU/ACW staff assume responsibility other than nursing care of the detainee.

14. During mortar attacks detainees will not be taken out of the facility. A blast blanket will be placed over the detainee and one provided for the guard as well.

15. Medical care of detainees includes 3 meals per day. Water is the only beverage to be provided. Special privileges are not allowed. Do not give cookies, candy, Pepsi and Coke or make promises, etc. These are considered special privileges.

16. Staff is not to interfere with the guards in their ability to provide security nor are guards to interfere with the delivery of health care.

17. All coordination for detainee movement outside this facility must be made through the responsible security force and the TOC.

18. Detainees will be given the same level of care as all other patients. Documentation upon admission must clearly note the condition in which the patient arrives (e.g., abrasions, bruises, lacerations, etc.). The same diligence to documentation is to occur throughout their admission stay and concise discharge notes are to be completed prior to transfer to Detention Facility or release to capturing nation.

OPI: Wardmaster  
Effective:  
Revised

<p style="text-align: center;"><b>APPENDIX 25 TO ANNEX D USOP 2800-3: IN-PATIENT SERVICES (IPS) VISITORS</b></p>
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PURPOSE

1. To clearly outline the guidelines for all patient visitors in the Acute Care Unit Multinational Medical Unit (ACU MMU) focusing on the three sections:

Resuscitation (Resus), Intermediate Care Ward (ICW), and the Intensive Care Unit (ICU).

APPLICABILITY

2. All RN/NO staff and Wardmaster assigned to MMF In-Patient Services (IPS) and the Duty Officers of the Tactical Operations Centre (TOC).

SOP

3. **ELIGIBILITY:** All civilian Registered Nurse (RN) / Nursing Officer (NO) staff at the ACU MMU and TOC Duty Officers.

**RESPONSIBILITIES – VISITOR(S) RECEPTION/DEPARTURE:**

a. TOC Duty Officer:

- (1) Perform responsibilities IAW ref A;
- (2) Confirm with Charge Nurse if patient can accept visitor(s) from clinical, security, and work environment perspectives;
- (3) Contacts IPS representative – NO or Wardmaster – to escort visitor(s) from the TOC to the patient; and
- (4) Receives and takes responsibility for visitor(s) from IPS representative when patient visit completed.

b. ACU MMU NO/RN/ Wardmaster:

- (1) Checks with patient/nurse whether they wish to have visitor(s) and uses interpreter as required;
- (2) Informs TOC if visitor(s) can visit and reason(s) why visitor(s) can/cannot see the respective patient;
- (3) Receives visitor(s) from TOC and escorts them to the patient's bedside;
- (4) Ensures guards are advised of visitor(s) if Local National (LN)

- (a) Informs TOC if too many LNs for one guard;
- (b) Escorts visitor(s) back to TOC and informs guard of their departure; and
- (c) Wardmaster re-evaluates need for extra guard as required.

c. Guards:

- (1) Will be responsible for guarding all LN patients and visitors as directed by Wardmaster and IAW ref B.

4. RESPONSIBILITIES: VISITING HOURS/SPECIAL CIRCUMSTANCES

a. All MMU staff:

(1) LN Visitors:

- (a) Visiting Hours for IPS shall be between the hours of 0900 – 1530 for LN visitors.

(2) Coalition Visitors:

- (a) Visiting Hours for IPS shall be between the hours of:

- i. 0900 – 1200;
- ii. 1300 – 1600; and
- iii. 1800 – 2000.

(3) Special Circumstances (LN visitors):

- (a) Critically unstable/palliative patient. All due diligence is to be considered to provide the family and patient the opportunity to be at the bedside. Therefore, visiting hours and/or length of visit can be tailored to meet their needs at the discretion of the physician and charge nurse;
- (b) Minors. As the MMF can be a frightening and daunting environment for a minor (under 18), a family member can stay with the patient 24 and 7 if so desired and space within the facility allows under the direction of the Charge Nurse or OIC IPS;
- (c) Political/VIP visitors. Under the direction of the Task Force Surg/CO, visiting hours can be amended to accommodate this group. For after hours, direction is to be provided by the Duty MO in consultation with the Duty O (TOC) and Charge Nurse.

Facility demands such as disruption, workload, space, availability of guards, and feasibility of their claim needs to be considered and/or verified in the determination of these timings. Otherwise their visiting hours are the same as para 3(a) (i). The chain-of-command for Host Nation Security Force patients are to be given the same due process as given to NATO equivalent IAW para 3(iv)(a) of this SOP; and

- (d) After hours:
  - i. Visitors under special circumstances allowed to stay overnight in the facility are to be treated with dignity and respect;
  - ii. Cultural needs are to be supported unless detrimental to their family member's recovery;
  - iii. Use of the interpreter and padre is encouraged to ensure patient/family needs are being met, questions are answered regarding care and/or regulations being followed;
  - iv. Family members are to sleep on the floor and provided blankets and pillows to ensure all beds are ready to respond to incoming patients; and
  - v. Family members are to be fed and provided water, chairs, and access to bathroom facilities but are not to wander the facility and must be in the presence of a guard.
- (4) Special Circumstances (Coalition):
  - (a) Charge Nurse will liaise with the Duty O (TOC) to ensure the appropriate chain-of-command is afforded the opportunity to visit with their troop(s) when patient condition warrants;
  - (b) Duration of their visit is dependent on the patient status/prognosis and must be kept in line with the same opportunity we would provide to a family member but should not interfere with the delivery of health care; and
  - (c) Use of support structures such as the padre and mental health, through the TOC, are encouraged.

**5. RESPONSIBILITIES – ADDITIONAL GUIDELINES:**

- a. All MMF Staff:

- (1) Number of visitors:
  - (a) Unless otherwise directed by TFSurg, OC IPS, the number of visitors shall be limited to 2 per patient at a time in the Intermediate Care Ward (ICW) and 1 visitor per patient at a time in the Intensive Care Unit (ICU);
  - (b) Diligence must be given to the overall space in the facility when considering the number of visitors and its impact on the ability for staff to deliver quality health care; and
  - (c) For Afghan visitors, the ability of the guard to perform his/her duties and number/availability of additional guards to observe these visitors must be considered before allowing further visitors in the facility.
  
- (2) Safety:
  - (a) All LN visitors are to be cleared at Entry Control Point (EPC) 3 of weapons, cell phones, and other electronic video and/or communication gadgetry;
  - (b) All LN visitors are to be guarded IAW ref B; and
  - (c) If the safety of the staff or patients is ever in jeopardy, all visitors will be removed from the facility.
  
- (3) Detainees:
  - (a) Any visitor(s) for detainee(s) can only occur under the direct authority of the JTF Commander.
  
- (4) Visitors in the Trauma Bays:
  - (a) Visitors are not allowed in the trauma bays inside the red square unless directed by the Trauma Team Leader;
  - (b) Visitors are allowed to be on the periphery of the trauma bay but not in such a place as to disrupt the flow of the trauma response;
  - (c) LN visitors shall have an interpreter present, if possible, to allay questions and provide comfort; and
    - (d) No more than 2 visitors in the trauma bay area at one time unless otherwise directed by the TFSurg, OC IPS.



- (5) Death of a patient:
- (a) Families and units must be allowed the opportunity to grieve and visit the patient;
  - (b) The number of visitors at a given time is to be at the discretion of the TFSurg, OC IPS and/or designate after hours – Duty MO, Charge Nurse and based on current tempo, space, disruption of health care provision, and availability of guard (for Afghan visitors);
  - (c) Support structures necessary to assist in the grieving process are to be implemented, through the TOC and/or with the interpreters, and should not prevent visitors from being present;
  - (d) Charge NO is to inform the TOC of the death; and
  - (e) The TOC will contact Mortuary Affairs.

OPI: Wardmaster  
Effective:  
Revised

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**APPENDIX 26 TO ANNEX D**  
**USOP 2800-4: PROCEDURES DURING INDIRECT FIRE (ROCKET ATTACK)**

PURPOSE

1. To outline the orders regarding the procedures to be followed during a rocket attack as it applies to staff and patients in the MMU.

APPLICABILITY

2. All staff assigned to MMU.

POLICY

3. All staff will don Personal Protective Equipment (PPE) IAW CO and Task Force directives.
4. All ambulatory patients are to be moved to the bunkers situated outside the Acute Care Ward. Staff will assist patients to wheelchairs if necessary.
5. Vented patients and patients assessed as unsafe to be moved will be covered by blast blankets and have helmets secured. Only the minimum number of staff required to provide safe nursing care are to remain in building.
6. Detainees must remain in the facility. The detainee and the guard will each be given a blast blanket and helmet to wear.
7. All remaining staff, interpreters and visitors will go to the bunkers.
8. In the event of casualties, major medical incident, or MASCAL:
  - a. Patients and visitors currently in the bunkers are to remain with a minimum number of medical staff to provide care if required;
  - b. The Charge Nurse is to report to the TOC and get a report on the types and number of casualties;
  - c. Provide the TOC with the names/position of personnel required to respond to the 9-liner (on-call staff; Trauma Activation; OC IPS) and ensure TOC arranges transportation and/or notification of these personnel; and
  - d. Get an interpreter from the bunker for incoming Afghan casualties as applicable.
9. Staff not on duty must be prepared to respond to their pagers and/or the ambulance with flashing lights parked outside of the designated meeting area.

**NOTE:** Staff responding to a page without vehicle transfer will don their PPE before coming to the hospital due to the frequency of multiple volleys of rockets.

10. When *all clear* alarm is sounded, staff will assist patients in the bunker to their beds. All patients will have their PPE removed and medical status re-assessed.
11. The charge nurse is to take roll call of all staff in the facility and report to The TOC.

OPI: OC In Patient Services  
Effective:  
Revised

<p style="text-align: center;"><b>APPENDIX 27 TO ANNEX D USOP 2800-5: TRAUMA TEAM ACTIVATION</b></p>
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PURPOSE

1. To provide a standardized guideline to be employed by the Charge Nurse/OIC In Patient Services ensuring appropriate and adequate staffing are made readily available in reaction to trauma patient's needs within the MMU.

APPLICABILITY

2. All staff at the MMU, in particular the Charge Nurse, Duty Medical Officer, and OC In Pt Svcs.

POLICY

3. Upon reception of a "9 Liner" report of incoming casualty(s), the TOC will notify the Duty MO, Charge Nurse and Primary Care Shift IC.

4. Based on the severity of the casualties' injuries, the Duty MO, Charge Nurse, OCs IPS or OPS, will action the Trauma Activation Protocol for any of the following situations and/or criteria:

- a. Priority A or B;
- b. Pre-Hospital Index  $\geq 4$ ;
- c. Hemodynamic Instability;
- d. Penetrating Torso Trauma;
- e. Casualty GCS  $< 13$ ;
- f. Polytrauma;
- g. Multiple Casualties; and
- h. At the discretion of Duty MO and/or Charge Nurse.

5. Once trauma activation has been initiated, the TOC Duty Officer will call the following team members:

- a. Trauma Team Leader(s) (Duty MO, General Surgeon, or designate);
- b. General Surgeon;
- c. Orthopedic Surgeon;
- d. Anesthesiologist; Neurosurgeon (*or designated*);

- e. Intensivist;
- f. Radiologist;
- g. Laboratory Technician;
- h. Diagnostic Imaging Technician;
- i. Shift IC OR and;
- j. Nurses and Medical Technicians to adequately staff the trauma team(s).

OPI: OC In Patient Services  
Effective:  
Revised

<p style="text-align: center;"><b>APPENDIX 28 TO ANNEX D</b> <b>USOP 2800-6: VOLUNTEER SERVICES DUTIES AND RESPONSIBILITIES</b></p>
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PURPOSE

1. This SOP is to serve as a guideline for the areas of responsibility volunteers will adhere to while employed in the MMU. The OC In Patient Services (IPS), Charge Nursing Officer or the Wardmaster In Pt Svcs may assign further duties as required.

APPLICABILITY

2. All volunteer staff providing non-clinical patient services at the MMU.

SOP

3. Volunteers may consist of NATO personnel, but not Locally Employed Persons (LEPs) or others where:

- a. Patient confidentiality and safety cannot be assured or protected; and/or
- b. As determined by the OC IPS or Wardmaster IPS.

4. Volunteers must provide their name, contact information, supervisor's name and contact information, and their unit/employer.

5. All volunteers must have written permission from their immediate chain of command/supervisor prior to commencing volunteer duties at the MMF.

6. Volunteers will only be employed in IPS section of MMF unless otherwise tasked by the OIC, Wardmaster or Charge Nurse.

7. While recognizing volunteers perform a valuable supporting role for both our staff and patients, they are not trained medical staff and are not to be considered or given tasks as such. Therefore, the following is a list outlining the duties and responsibilities of the MMF volunteer:

- a. Patient transport;
- b. Stretcher bearer;
- c. Runner in the trauma bays
- d. Biohazardous and general waste removal;
- e. Laundry preparation and restock;
- g. Patient feeding;

- h. Patient hygiene;
  - i. Assist with dressing change;
  - j. Oxygen tank - check/exchange/hook up;
  - k. Ward restock; and
  - l. Patient log roll/positioning.
8. Military volunteers must:
- a. Adhere to the dress and weapon state IAW TF Comd direction and MMF SOPs;
  - b. Dress of the day during their shift; and
  - c. Provide the OC or Wardmaster IPS with their unit direction WRT the alarm response during their shift (i.e. report to unit, call unit, etc.).
9. All volunteers must sign and abide by the MMF Volunteer Confidentiality Agreement (Tab A);
10. Volunteer staff will report to the Wardmaster IPS for orientation and a description of their duties on their first shift. During this time they will complete the mandatory training program.
11. All volunteers will report to the TOC at the start of their shift to sign in and for ID pick up. They will report to the Wardmaster and/or Charge Nurse for assignment of duties. At the end of their shift they will sign pout at the TOC and return the ID.
12. Volunteer staff will wear a nametag clearly indicating they are volunteers;
13. Volunteers will inform the Wardmaster or Charge Nurse if they are unable to report for their shift.
14. All work performed by the volunteer staff will be done under supervision of the IPS staff and will not consist of clinical duties.
15. At no point will volunteers assume independent clinical duties or responsibilities.
16. Volunteers will act professionally and perform their duties with the utmost respect and dignity towards the staff and patients admitted to MMF.
17. If at any time, a volunteer believes he/she has been treated unfairly and/or in an unprofessional manner, he/she is to inform the Wardmaster or OC IPS immediately.



18. Failure to abide by this SOP and/or unprofessional conduct may result in immediate termination of their volunteer status at the Role 3 MMF. Multinational Medical Unit (MMU) Volunteer Confidentiality Agreement, see following pages

OPI: OC In Patient Services

Effective:

Revised

**Tab A - Multinational Medical Unit (MMU) Volunteer Confidentiality Agreement**

1. MMU volunteer staff will not discuss any patient related information with anyone other than authorized medical staff employed at the MMU.
2. Volunteers will in no way represent themselves as clinical staff and shall where a nametag clearly indicating that they are volunteers.
3. Volunteers must have the written permission of their Chain of Command to volunteer at the MMU.

I. hereby agree to abide by the MMU Volunteer Confidentiality Agreement as noted above.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print

<p style="text-align: center;"><b>APPENDIX 29 TO ANNEX D</b> <b>USOP 2800-6: WARDMASTER and 2 I/C DUTIES AND RESPONSIBILITIES</b></p>
---

PURPOSE

1. This SOP is to serve as a basic guideline for the duties and responsibilities of the Wardmaster and Ward 2 I/C positions. This is not an all-inclusive guide and further duties may be assigned by the Chief Nursing Officer or Section Nursing Officer, and the CSM. It is assumed that the term Wardmaster is inclusive of the 2 I/C in the Wardmaster's absence.

APPLICABILITY

2. All staff assigned to MMU Ward and ICU.

SOP

3. The Wardmaster's primary responsibilities are to facilitate the smooth operation of the Ward and Trauma Bays by providing logistical support and managing the Medical Technicians. The position of Wardmaster is a regularly scheduled day job. The Wardmaster shall ensure the following:

- a. Will ensure the overall safe delivery of patient care on all patients admitted to the MMU Hospital;
- b. Will perform cursory inspections of all trauma bays daily;
- c. Shall inspect bulk medical equipment storage areas and restock accordingly on a daily basis;
- d. Shall provide advice to OC In-Patient Svcs, 2 I/C In-Patient Svcs, Charge Nurse and CSM regarding Medical Technician issues;
- e. Shall keep OC and 2 I/C In-Patient Svcs informed regarding any issues effecting the Medical Technicians or the operation of the Ward;
- f. Will provide assistance to nursing staff in either the ICU or Acute Care Ward on an as needed basis;
- g. Will provide guidance to the Medical Technicians employed on the ward regarding both clinical and administrative issues;
- h. Will ensure that laundry is put away and that the blanket warmer is stocked daily;
- i. Confirm patient diets, distribute meals and dispose of leftover food no more than two hours after the seals on the food containers are broken;

- j. Ensure patient documentation is completed at the end of each shift;
- k. Ensure that the ward fridge is restocked at the end of each shift;
- l. Shall upon receipt of a "9-Liner" assign Medical Technicians to the Trauma Bays in accordance with their skill and experience levels and advise Charge Nurse regarding dispositions;
- m. Ensure daily checks of defibrillators are completed;
- n. Ensure Biohazardous waste is taken to the Biohazard bin once per shift;
- o. Review "Med Tech Duty" checklist upon arrival at work to ensure completeness;
- p. Prepare evaluations for Medical Technicians;
- q. Ensure that medical and general stores requests are prepared and submitted in a timely manner in accordance with unit protocols and practices;
- r. Ensure dust filters on the heating/cooling units are changed weekly;
- s. Liaise with Medical Equipment Repair Shop regarding ongoing routine and emergent medical equipment maintenance issues;
- t. Liaise as required with all other departments;
- u. Perform any other duties as assigned by the Charge Nurse, OC, or CSM; and
- v. Monthly duties;
  - (1) Submit end month mileage to Tpt Representative;
  - (2) Submit monthly ration requisitions on behalf of in-patients and duty staff; and
  - (3) Complete Medical Technician schedules on a monthly basis.

OPI: OC In Patient Services  
Effective:  
Revised

<p style="text-align: center;"><b>APPENDIX 30 TO ANNEX D</b> <b>USOP 2900-1: CONDUCTING 9-LINERS ARRIVING AT THE MMF</b></p>
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PURPOSE

1. To establish standardized guidelines for conducting 9-liners arriving at the MMU.

APPLICABILITY

2. This practice guideline applies to all Medical, Nursing, and Medical Technician personnel working in the MMU as well as any other personnel that might be called upon to respond to 9-liners on the flight line such as medical personnel from other coalition countries.

POLICY

3. The shift I/C is responsible to report to the TOC when the call for a 9-liner is received at Primary Care.
4. Only the MMU In Patient Services Sergeant Major, Non Commissioned Officer (NCO) I/C Primary Care or the shift I/C may act as the on-scene commander on the flight line.
5. The shift I/C will give report to all Med Techs on duty upon return to Primary Care from the TOC, and will assign Med Techs for the flight line depending on the number of casualties arriving on the 9-liner.
  - a. When the ambulance is used to transport the casualties, a Med Tech will be assigned as the attendant in the ambulance once the first casualty is loaded in to the ambulance and will remain with the patient until offloaded at the trauma bay doors.
6. The shift I/C will make the decision between using the ambulance or rickshaw on the flight line to transport casualties to the trauma bays, depending on the number of casualties and the severity of their injuries.
7. The on-scene commander will keep comms with the TOC at all times while on the flight line via portable radio.
8. The on-scene commander will inform and ensure that any bystanders do not interfere with the offloading of the aircraft and loading into the ambulance on the flight line.
9. The shift I/C will assign Med Techs to the trauma bay when asked by the Ward master during day shift and by the charge nurse during silent hours.
  - a. Special consideration should be made when requesting for a Primary Care Med Tech to assist in the trauma bay since they must first complete all

patient transportation. This is especially the case during silent hours.  
The shift I/C will ensure that the ambulances are cleaned after each 9-liner.

10. The shift I/C will ensure that the stretchers used for casualty transport are cleaned prior to the end of shift after the stretchers have been brought out of the trauma bays.

OPI: OC In Patient Services

Effective:

Revised

<p><b>APPENDIX 31 TO ANNEX D USOP 3000-1: QUALITY ASSURANCE</b></p>
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**PURPOSE**

1. The purpose of this USOP is to outline the procedures to be used to bring attention to issues regarding the quality of healthcare delivery at the MMU.
2. The process outlined in this SOP does not prevent direct reporting of a concern (safety, clinical, ethical, etc.) to supervisors or MMU Chain of Command as required. Being ultimately responsible for all activities within the MMU, the Commanding Officer may be approached directly by any staff member that feels their concern is not appropriate to be raised at a lower level.

**BACKGROUND**

Quality Assurance

3. High quality health care is assessed on the total appropriateness and suitability of care as perceived by patients and health care professionals, including compliance with clinical guidelines and best practices. The MMU must provide quality patient-centered care while balancing clinical best practices and operational requirements.
4. Quality Assurance (QA) is an organizational philosophy that seeks to meet clients' needs and exceed their expectations by using a structured process that selectively identifies and improves all aspects of service. QA focuses on excellence but also recognizes the inherent risks involved in delivering health care.
5. Incorporating QA processes into the daily practice of health care facilitates the evaluation and improvement of health care systems and processes. The emphasis is on using evidence to determine how the system is working and what improvements need to be made.
6. Continuous QA is an interdisciplinary endeavor. Expertise from all areas is required to ensure that health care systems and processes, including patient care, are continually improved.
7. The MMU leadership team, and indeed all staff, is accountable for ensuring that they provide high quality clinical care in accordance with established standards and that resources expended in providing this care are managed appropriately. The environment must provide a non-punitive environment and encourage the reporting of errors and standard of care concerns.
8. By ensuring a QA Program is in place and documented the MMU will have established a framework for QA that addresses both excellence of care and risk management. Risk Management

9. Risk refers to circumstances that may prevent or impede the attainment of objectives. It includes failure to recognize and seize upon opportunities. The objectives at risk can be strategic, operational, financial or compliance.

10. Risk management (RM) is a systematic approach to setting the best course of action under uncertainty by identifying, assessing, understanding, acting on and communicating risk issues. Integrated RM furthers the objectives of RM through a continuous, proactive and systematic process to understand, manage and communicate from an organization-wide perspective. It is about making strategic decisions that contribute to the achievement of an organization's overall objectives.

- a. The process consists of four steps:
  - (1) Risk Identification;
  - (2) Risk Assessment/Analysis;
  - (3) Risk Response; and
  - (4) Risk Evaluation.
- b. Risk response can entail a number of alternative approaches such as:
  - (1) Recognizing the risk but not taking any action;
  - (2) Using an alternative approach thereby eliminating or reducing the situation which gives rise to the risk;
  - (3) Transferring the risk to another party such as by contracting the specific activity that would have generated the risk;
  - (4) Preparing a contingency plan in the event the risk occurs; and
  - (5) A combination of the above or other approaches.

11. Linkages between the QA and RM programs identify opportunities for organizational improvement, improved effectiveness and efficiency and minimizing adverse patient effects.

12. Quality Assurance/Risk Management Team. The QA/RM Team will ensure that a continuous QA/RM program is established and maintained in the MMF to monitor the quality of services provided and identify and address opportunities for improvement.

13. Patient Safety

- a. In the last few years the issues of patient safety and health care error have become important topics in health policy and health care practice.



Increasing patient safety by reducing health care error and adverse events is an essential aspect of the Quality Assurance and Risk Management Program; and

- b. Patient safety is the prevention and mitigation of unsafe acts within the health care system. Strategies for improving patient safety include creating a culture that supports the identification and reporting of unsafe acts, effective measurement of patient injuries and other relevant outcome indicators. Even with the best systems in place, things sometimes go wrong. Improving the safety of patients is about creating an environment that is open to disclosure and committed to change.

## DEFINITIONS

14. Occurrence Rating Scales. A level of risk is assigned to all occurrences based on severity of outcome. Examples of ratings are;

- a. None. Any reported incident where a patient was not directly involved. This includes dispensing-related and order-related events noted prior to any patient involvement;
- b. Low. No harmful effect to the patient but potential risk identified. This pertains to falls in which no injury was sustained but there was potential for injury. In medication incidents, the therapeutic effect of the drug was not altered but the administration or omission of the drug was inappropriate: The patient sustained minimal effects and a minimal risk to the patient was identified;
- c. Moderate. Moderate to harmful effects to the patient and high potential for risk was identified. This includes moderate lacerations, burns and pain. These conditions may require extended observation, or may or may not prolong length of stay. In the case of medication incidents, effects were likely to occur if there had been continued administration or omission of the drug; and
- d. High. The patient had serious harmful effects that required immediate intervention to resolve or prevent further deterioration of the patient's condition. A drastic outcome includes a patient suffered permanent injury or death, such as death occurring during surgery or post-anesthetic care, falls inducing injury, medication errors or significant adverse reactions, procedural or treatment error, etc.

15. Sentinel Events. A sentinel event is a type of adverse event or occurrence. A sentinel event is an unexpected incident, related to system or process deficiencies, which leads to significant consequences or major and enduring loss of function for a recipient of health care services. Major and enduring loss of function refers to sensory, motor, physiological, or psychological impairment not present at the time services were sought or began. The impairment lasts for a minimum period of two weeks and is not related to

an underlying condition. Sentinel events also include events that have or could have catastrophic impact on the organization's financial, human and physical resources. All adverse events, including sentinel events, are captured in the Occurrence Reporting process and promptly reported to the QA/RM team.

## **POLICY AND PROCEDURES**

16. Occurrence reporting is used to discover faulty systems or processes that do not support clinicians in their roles or have the potential to lead to adverse events. Events occur when safeguards are deficient, missing or fail; with unidentified or improperly understood risks; or when changes create unidentified risks or defeat the existing safeguards.

17. Occurrences are preventable *events* that may cause harm to people, the environment or the organization. An occurrence is an event, accident or circumstance that resulted in, or could have resulted in an unintended, undesired outcome. Reporting of such events is an integral part of QA and RM.

18. Occurrences involving patients or staff members require proper documentation. The MMF Occurrence Report is designed to facilitate recording of an event or occurrence. The objective of the integrated Occurrence Reporting System is to communicate information to appropriate members of the MMF staff regarding unusual occurrences, which require investigation and/or resolution.

19. The person or persons most directly involved, or by those who observed or discovered the unusual occurrence will immediately report it. The occurrence will be reported on the MMF Quality Assurance Report. The information is confidential. To minimize loss associated with an unusual occurrence, staff and management must expedite the communication of unusual occurrences to their immediate manager, who will complete the QA Report for Management Action/Follow-Up Report.

20. Clinic staff who wish to remain anonymous are expected to report occurrences or events by completing the Quality Assurance Report and placing it in the QA box at the main entrance of the Role 3.

21. Permanent members of the QA/RM team shall be the MMU Officer Commanding, Company Sergeant Major and JTTS Coordinator. Additional ad hoc members will be added where specific expertise is required.

22. The QA/RM team shall meet weekly to review issues raised, or more frequently if indicated.

23. The Officer Commanding MMU is responsible for ensuring the required immediate and follow-up action is taken. The documentation is forwarded to the QA/RM Team who review all reports. The reports, with action plan, are forwarded to CO Role 3 for consideration. All staff of the MMU having concerns they feel need to be brought directly to the CO MMF may do so.

Quality Assurance Report, see Tab A

OPI: OC In Patient Services

Effective Date:

Revised:

**Tab A - Quality Assurance Report  
MMU QUALITY ASSURANCE REPORT**

Date and Time of Incident	Incident Number (For Quality Assurance Staff Completion)
Name of Reporter (Optional)	Name of Person Involved
Date of Report	Status of Person Involved <input type="checkbox"/> Patient <input type="checkbox"/> Staff <input type="checkbox"/> Visitor <input type="checkbox"/> Other
Exact Location of Incident	
1. Involving <input type="checkbox"/> Patient <input type="checkbox"/> Staff <input type="checkbox"/> Visitor <input type="checkbox"/> Property <input type="checkbox"/> Medical Records <input type="checkbox"/> Equipment <input type="checkbox"/> Supplies <input type="checkbox"/> Utilities	
2. Report Concerns <input type="checkbox"/> Outpatient Services Administration <input type="checkbox"/> Primary Care <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Mental Health	2. Report <input type="checkbox"/> Inpatient Services <input type="checkbox"/> Intensive Care <input type="checkbox"/> Ward <input type="checkbox"/> OR <input type="checkbox"/> Clinical Support Svcs <input type="checkbox"/> Lab <input type="checkbox"/> X-Ray <input type="checkbox"/> Pharmacy <input type="checkbox"/> Dental Services
3. Details of Complaint	
4. Remedial Action	
5. OC Role 3 Signature	5
6. CO Role 3 Signature	6

<p style="text-align: center;"><b>APPENDIX 32 TO ANNEX D USOP 7500-1: AUTHORIZED IMAGERY WITHIN MMU</b></p>
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PURPOSE

1. The purpose of this policy is to regulate the production of photography and/or video recordings of patients within the MMU with respect to patient confidentiality and consent.

ASSUMPTIONS

2. All care providers within the MMU are part of a professional team and are ultimately responsible for the safe ethical care of all patients.

3. Working within the context of a professional team, any recordings of patients will be for the sole purpose of teaching, medical publications or the advancement of care.

4. Confidentiality is the patient's right and, under most circumstances, may be waived only by the patient or by someone legally entitled to do so on his or her behalf.

5. For the purpose of this policy "recording" will refer to photography and video recording, either conventional or digital.

6. It must be recognized that by their nature digital recordings are easier to manipulate and distribute and therefore particular care must be exercised to protect the integrity and confidentiality of these recordings.

7. Obtaining consent for recordings only in cases where full length or facial recordings from which patients can be easily identified is not sufficient. It must be recognized that patients may be identifiable by marks such as tattoos, scars or injuries. Therefore it is not acceptable to rely of the photographer's judgment that a patient is unlikely to be identified by a recording.

8. In all cases of recording, care must be exercised to respect the dignity, cultural and religious beliefs of the patient.

9. Operational security, patient welfare, patient privacy, and Next of kin (NOK) /family considerations are the governing concerns related to media coverage of wounded, injured, and ill personnel located in medical facilities or other casualty collection and treatment centers. Permission to interview or photograph a patient, including those inside operating rooms during operating procedures, will be granted only with the consent of the attending physician or facility commander and with the patient's informed consent, witnessed by the person responsible to escort embedded journalists. "Informed consent" means the patient understands his or her picture and comments are being collected for news media purposes and they may appear in any news media reports. The attending physician will confirm that the individual is medically capable of giving informed consent. In all cases disclosure of information will adhere to paragraphs 3b, 7 and 8 of the Privacy Act.

10. POLICY

11. Records should only include the specific area of injury. Whole body shots should be taken only if completely necessary. Every effort will be made to preserve the patient's dignity and privacy.

12. Trauma Bays/Major Incidents. Within the Trauma Bays of MMU, the Unit Photographer or designate and/or National Imagery Team personnel who have identified themselves as such, are the only personnel authorized to take recordings. CO/DCO/RSM or any other delegated authority by the CO can authorize the presence of external media, imbedded media or National imagery teams within the facility. Media visits to medical facilities will be in accordance with applicable regulations, standard operating procedures, operations orders and instructions by attending physicians. If the Commander authorizes embedded journalists to visit a TF medical facility, medical personnel must escort the embedded journalists at all times. Visits must not interfere with medical treatment. Media will not interview or photograph a patient/casualty without the patient's/casualty's informed consent. If applicable, the attending physician will confirm that the individual is medically capable of giving informed consent. Imagery depicting the transport or transfer of casualties is permitted so long as the injured person(s) and the injuries suffered cannot be visually identified.

13. Flight Line/Airfield Photography. The taking of photographs is prohibited along the flight line. This included all runways, taxiways, and aprons.

14. Ward/ICU beds. It is the responsibility of the Charge Nurse to monitor recordings taken in their area and to ensure proper consent is obtained.

15. Operating Suite. It is the responsibility of the OR Nurse to monitor recordings taken within the operating suites and to ensure proper consent is obtained.

16. Consent. Every attempt must be made to obtain an informed witnessed consent prior to taking recordings of patients. In the case of an unconscious patient, informed consent must be obtained when the patient regains consciousness. If the patient does not consent, any recordings must be deleted / destroyed.

17. Minors. Recordings of children should be taken only if there are specific features that need recording for clinical reasons, such as progression of wound healing, or for teaching, such as an important clinical sign rarely seen. Every attempt must be made to obtain consent from the legal guardian before taking images.

18. Deceased. There will be absolutely no photography of the deceased in the facility. Anyone violating this policy will be subject to disciplinary action.

**PROCEDURE**

19. In the event that consent cannot be obtained prior to recordings being taken, recordings will be held until such time that consent is obtained. If the patient declines to consent the recordings must be deleted / destroyed.

20. In the event that the patient is immobilized or otherwise unable to sign his or own consent; the consent may be given verbally and witnessed by two witnesses.

21. All photographic records will be kept on the unit's external hard drive, not on drives accessible to all users. The responsibility for this drive will rest with an Officer designated by the CO thus ensuring security of all photographic records and unnecessary dissemination.

Consent form to be photographed, see Tab A

OPI: DCO  
Effective:  
Revised:

**Tab A - Consent form to be photographed**

The Multinational Medical Unit respects your right to control the use of photographs taken of you during your treatment within the hospital.

In view of the explanation given to me by \_\_\_\_\_  
Rank Name

Nationality

I do/do not consent to photographs being taken to track my medical progress and for my personal medical records.

I do/do not consent to photographs being made available for teaching amongst healthcare professionals.

I do/do not consent to my photographs being published for the purpose provided below.

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Signature of patient/guardian \_\_\_\_\_ date: \_\_\_\_\_

Signature of clinician \_\_\_\_\_ date: \_\_\_\_\_

If patient is unable to sign, verbal consent may be obtained, but must be witnessed;

Signature of witness #1 \_\_\_\_\_ signature of witness #2 \_\_\_\_\_  
date: \_\_\_\_\_ date: \_\_\_\_\_



**ANNEX E: MULTINATIONAL MEDICAL UNIT SECURITY**

**GENERAL**

1. This USOP details the instruction and information on the actions and procedures relating to the security of the unit. The USOP details the minimum levels of physical protection to be employed in countering the current threat.

2. The security of Camp (insert name of Camp) is provided by the Force Protection (FP) element. However it is incumbent upon all Force Elements (FE) to be security aware at all times, to remain vigilant and to take sensible precautions.

**CAMP (insert name of Camp) SECURITY MEASURES**

3. Threat state:

Ser (a)	Threat Level (b)	(Insert name of Camp) Security (c)
1	<b>GREEN (LOW)</b>	1. Random vehicle and personnel searches as directed. 2. Routine patrolling
2	<b>YELLOW (MEDIUM)</b>	1. All vehicle searched on entry.
3	<b>AMBER (HIGH)</b>	1. Implement Camp (insert name of Camp) Defence Plan. 2. No entry to camp less (insert authorized forces) personnel.
4	<b>RED (HIGH-SPECIFIC)</b>	1. Implement Camp (insert name of Camp) Defence Plan. 2. No entry to camp less (insert authorized forces) personnel.

4. Alert/Dress state:

Ser (a)	Alert State (b)	Indicators (c)	Dress State (d)
1	<b>GREEN (LOW)</b>	<p><b>No specific threat to installation / personnel. A general threat of terrorist activity remains.</b></p> <p>No impact on normal activities.</p>	<p><b>Inside Camp</b> (insert name of Camp).</p> <p>1. Dress: Detail dress.</p>
			<p>2. Equip: Detail equipment to be carried.</p>
			<p>3. Wpn: Detail weapons state.</p>
			<p><b>Outside Camp</b> (insert name of Camp).</p> <p>1. Dress: Detail dress.</p>
			<p>2. Equip: Detail equipment to be carried.</p>
			<p>3. Wpn: Detail weapons state.</p>
2	<b>YELLOW (MEDIUM)</b>	<p>General intelligence that a terrorist threat exists against Coalition Forces (CF) in (insert specific AO) area of operations (AO).</p> <p>No impact on normal activities.</p>	<p><b>Inside Camp</b> (insert name of Camp).</p> <p>1. Dress: Detail dress.</p>
			<p>2. Equip: Detail equipment to be carried.</p>
			<p>3. Wpn: Detail weapons state.</p>
			<p><b>Outside Camp</b> (insert name of Camp).</p> <p>1. Dress: Detail dress.</p>
			<p>2. Equip: Detail equipment to be carried.</p>
			<p>3. Wpn: Detail weapons state.</p>
3	<b>AMBER (HIGH)</b>	<p><i>Confirmed intelligence that an attack is planned against CF and CF locations. General increase of hostile activity within hostile activity within (insert specific AO).</i></p>	<p><b>Inside Camp</b>(insert name of Camp).</p> <p>1. Dress: Detail dress.</p>
			<p>2. Equip: Detail equipment to be carried.</p>
			<p>3. Wpn: Detail weapons state.</p>
			<p><b>Outside Camp</b> (insert name of Camp).</p> <p>1. Dress: Detail dress.</p>
			<p>2. Equip: Detail equipment to be carried.</p>
			<p>3. Wpn: Detail weapon state.</p>

4	<b>RED (HIGH- SPECIFIC)</b>	Confirmed, specified intelligence of an attack on (insert name of Camp).	<b>Inside / Outside Camp</b> (insert name of Camp). 1. Dress. Detail dress. 2. Equip. Detail equipment to be carried. 3. Wpn. Detail weapons state.
		Significant increase in hostile activity in immediate vicinity of camp.	
		In the immediate area when an attack has occurred.	

5. Mandatory dress and equipment.

a. Detail the mandatory dress and equipment requirements for the Camp. For example “All personnel are to be dressed in desert combats and when travelling outside camp, webbing, ECBA, helmet, with First Field Dressing (FFD) and morphine. In addition personnel are to carry the following documentation:

- (1) Card A;
- (2) F/IDENT/189;
- (3) Service ID card and Discs;
- (4) ISAF ID Card (if issued);
- (5) Mine Awareness Card;
- (6) F Med 965;
- (7) F/IDENT107/8; and
- (8) Red Cross Arm Band.

6. All vehicles are to be parked 25m away from any tented accommodation with the exception of medical vehicles. Vehicle passes must be displayed at all times.

**SPECIFIED OPERATIONS**

7. There are four specified operations:

a. **OP (insert name of OP here):**

- (1) Indicate who initiates and how info passed on;

(2) Indicate specific measures to be taken on initiation of Op; and  
Indicate who to be informed on outcome and completion of Op.

b. **OP (insert name of OP here):**

- (1) Indicate who initiates and how info passed on;
- (2) Indicate specific measures to be taken on initiation of Op; and
- (3) Indicate who to be informed on outcome and completion of Op.

8. **ACTIONS ON INDIRECT FIRE ATTACK**

<b>REACT</b>	<p>If you experience / hear:</p> <ul style="list-style-type: none"><li>An explosion or impact.</li><li>A whistle sound overhead.</li></ul> <p>The sounding of a continual siren or horn.</p> <p>Take cover and warn others by shouting <b>"INCOMING"</b>.</p> <p>Put on ECBA and helmet.</p> <p>At night keep light to a minimum.</p>
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<b>ACCOUNT</b>	<p>All personnel are to remain under cover for 30 mins. The senior person present is to account for the location of all dept staff members.</p> <p>When alarm stops or the all clear is received personnel are to move to UNIT Emergency Rendezvous (ERV).</p>
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9. ACTIONS ON DIRECT FIRE ATTACK

<b>RECOVER</b>	<p>Be prepared to provide manpower as directed from UNIT Ops Center. On orders from UNIT Ops Center conduct (insert name of OP).</p> <p>Stand-down will be announced by the UNIT Ops Center and cascaded down through Depts.</p>
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<b>REACT</b>	<p>If you experience:</p> <ul style="list-style-type: none"><li>Rounds falling at your feet or those around you being hit.</li><li>Experience a crack or thump from small arms ammunition.</li><li>See unknown individuals pointing wpn systems in your direction.</li><li>Take cover and warn others. No unnecessary movement.</li><li>Put on ECBA and helmet.</li><li>At night keep light to a minimum.</li></ul>
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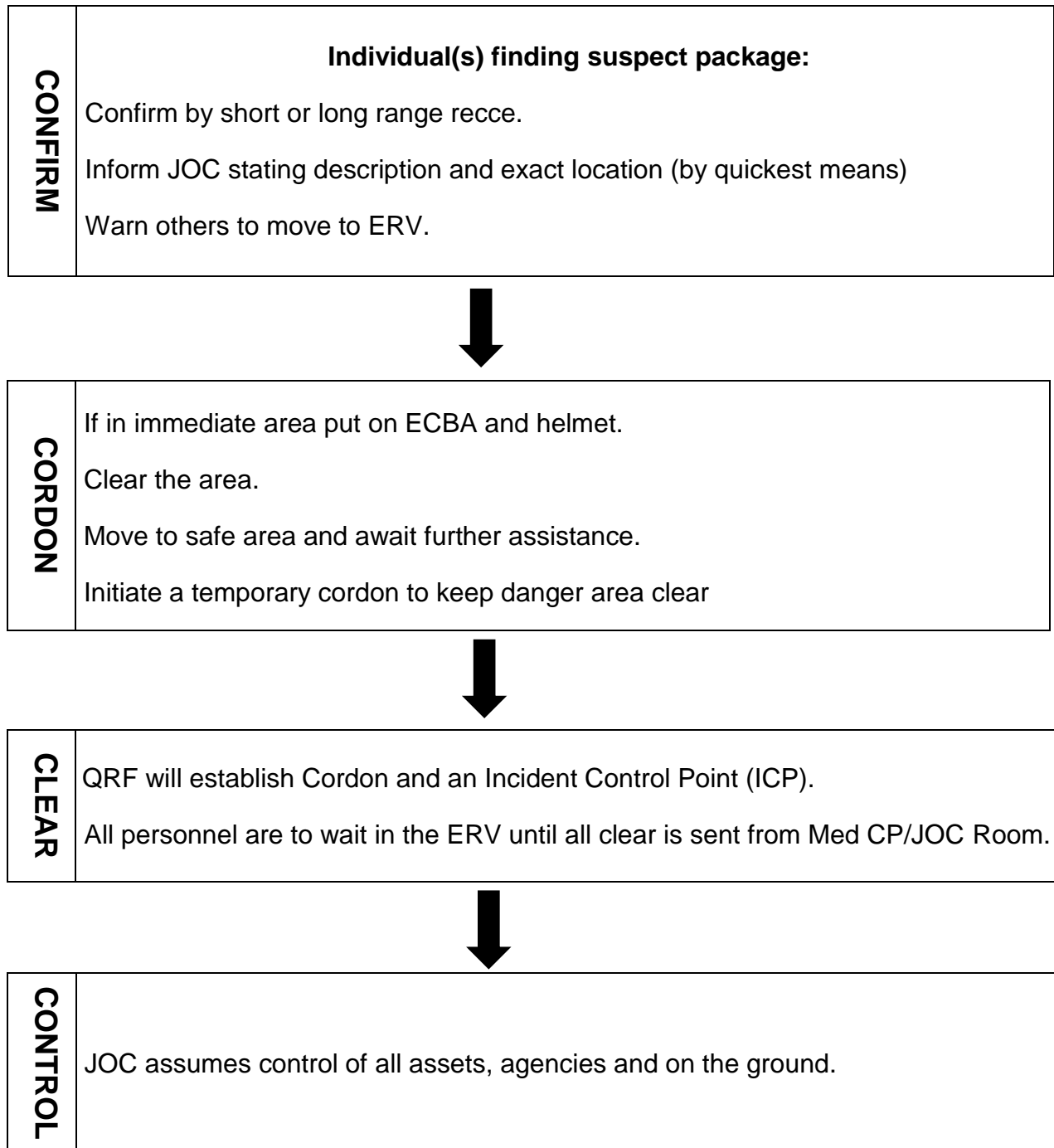


<b>ACCOUNT</b>	<p>Be prepared to provide manpower as directed from UNIT Ops Center On orders from UNIT Ops Center conduct OP (Insert name of OP).</p> <p>Stand-down will be announced by the UNIT Ops Center and cascaded down through Depts.</p>
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<b>RECOVER</b>	<p>All personnel are to move to UNIT ERVs.</p>
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10. ACTIONS ON SUSPECT PACKAGE



11. ACTIONS ON SUICIDE BOMBER

<b>IMMEDIATE</b>	Take cover and warn others. No <b>unnecessary</b> movement Put on ECBA and helmet. Prepare to engage from behind cover. Remain in cover, observe and task agencies through Med CP/JOC
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<b>CONTROL</b>	If in the immediate vicinity – put on ECBA, helmet and move to a safe area. Remainder move to Camp ERVs via a safe route. Wait in ERV until all clear is given from the Med CP/JOC.
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## **SECURITY OF SUSPECTED ANTI-COALITION MILITIA (ACM) IN THE HOSPITAL**

12. Whilst in the care of R3 Multinational Medical Unit (MMU) all suspect, ACM patients will be placed under a guard from the Detention Guard Force (DGF), therefore ensuring the safety of the staff, patients and the safety of the guarded patient.

13. The Garrison Sergeant Major (GSM) will dictate the guard rota, ensuring there is a guard present at all times. At no time is the patient to be left unattended, the guard will not “stand down” from his duty unless informed he can by the Hospital Management Cell (HMC) or the GSM.

14. The guard should be fully conversant with all R3 USOPs that are relevant to this task, and must check in and out with the HMC at start and end of all shifts.

15. The DGF personnel assigned to guard suspect in-patients and must remain alert and vigilant at all times, and will conform to the following protocols:

- a. An area will be set aside close to the detainee for the guard to sit or stand;
- b. ECBA and helmet are to be carried, and are to be readily available but not worn. Card A must also be carried;
- c. Weapon is to be unloaded;
- d. Will not leave his post until replaced or ordered to by the GSM or the HMC;
- e. Will ensure the patient does not acquire any dangerous items i.e.; ensure all sharps are out of reach and cutlery is removed after meal times;
- f. Know where the plastic-cuffs are;
- g. Act as a conduit to pass items to and from patient to staff when necessary; and
- h. Read any relevant Orders.

## **ACTIONS ON LEAVING THE WARD**

16. The only reason for the guarded patient to leave the ward is for washing, toileting, smoking or further medical examinations. If the patient leaves the ward for any reason the armed guard must accompany him at all times, unless directed by the medical staff.

17. When washing and toileting is required the armed guard and patient must be accompanied by a member of staff of the same sex.



### **ACTIONS ON MINOR AGGRAVATION**

18. If the suspect patient becomes agitated and the guard/ward staff feel the patient may become violent an interpreter must be called to help diffuse the situation. If the situation cannot be diffused refer to Para 20 (violent patient).

### **ACTIONS ON A VIOLENT PATIENT**

19. If the suspect in-patient(s) become abusive or violent towards the staff or each other, the armed guard is to diffuse the situation using the minimum force deemed necessary under the Rules of Engagement (Card A). If the outbreak of violence cannot be contained by the armed guard and the dept staff, then the SSM of the Hosp Sqn is to be informed immediately.

### **ACTIONS ON FIRE**

20. In the event of a fire, the guarded patient should be evacuated as any other patient would be, although his escort and a member of the ward staff must accompany him at all times.

### **INDIRECT FIRE ATTACK**

21. In the event of the Hospital coming under an indirect attack the guard is to comply with Para 8 with the following additions:

- a. They are to don their ECBA and helmet (if available);
- b. Once the all clear is sound, if the charge can be moved they are to be moved to the ERV; and
- c. If the charge cannot be moved the guard is to stay with the charge, adopting a low profile as close to the floor as possible to afford the best as possible protection.

### **DIRECT FIRE ATTACK**

22. In the event of the R3 coming under direct attack the guard is to comply with Para 9 with the following additions:

- a. They are to don their ECBA and helmet (if available);
- b. Once the all clear is sounded, if the charge can be moved they are to be moved to the ERV; and
- c. If the charge cannot be moved the guard is to stay with the charge, adopting a low profile as close to the floor as possible to afford the best as possible protection.

### **DISPOSAL OF SENSITIVE MATERIALS**

23. All correspondence and packaging received into theatre is a possible target for ACM/Taliban for the purposes of propaganda, and subversion. To that end all such materials are to be classified as sensitive and are subject to correct disposal procedures.
24. All packaging labels are to be removed and rendered unreadable if they include a postage address in theatre or a return address outside of theatre.
25. All work related scrap paper is to be torn in a minimum of quarters and placed into a Brown Paper Burn bag.
26. All personal letters and packaging from parcels are to be disposed of as per Para
27. All full burns bags are to be stored in the incinerator ISO container prior to incineration.

### **SUSPICIOUS SUBSTANCES**

28. All suspicious substances are to be withdrawn from the patient/soldier. The Hospital Sqn SSM is to secure the substance within the HMC safe and inform the RMP.

**INTENTIONALLY BLANK**

**AMedP-9.2(A)(1)**