A Medical Audit for TA Units

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SUMMARY: A system of medical audit of Territorial Army Units was introduced in 1980 in Western District and Wales. It is based upon a check list of those health maintenance requirements which can be monitored by the unit itself. The unit produces its own audit, weaknesses and deficiencies are easily identified, and executive remedial action is taken by the unit’s own staff.

Background

Western District consists of the counties of Staffordshire, Shropshire, West Midlands, Warwickshire and Hereford-Worcester and the writer’s responsibilities also cover the Principality of Wales. In this area there are 25 major Territorial Army (TA) units and 14 minor units or sub-units. Additionally there are 84 regular army units of different sizes where this system of audit is also used but in a modified form. Some TA units have their headquarters in these districts with sub-units or detachments in other districts, in many instances the converse is the case. The role of the TA units upon mobilization is to support NATO or to remain in home defence of the UK.

Medical Support in TA Units

The major units may have two medical officers and a full establishment of Medical Assistants (MA) or Regimental Medical Assistants (RMA). The smaller units often have no integral medical staff at all. Between these extremes there are variations of medical support. Unit geography is also relevant; typical is the unit with one company in Birmingham which has its regimental headquarters in Cardiff and sees its medical officer once a year in addition to annual camp. Some units rely upon help from a local RAMC TA Unit, but as there are only three in the two districts that assistance is fairly limited. Many units rely upon local civilian practitioners who will carry out medical examinations but rarely anything else.

Even where a unit has a medical officer there is the real practical problem of coinciding his training evening visit with that of those men needing his attention. Weekend training is not the answer, for a commanding officer is not ready to interrupt field exercises for routine medical procedures to be carried out. Annual camp is the usual time the unit is brought up to date medically, but this can only be done in the case of those units with doctors.

Regular Army regimental medical officers, now in post or recently so, will remember well that there is more to being an RMO than simply GP type doctoring. Much of the RMO’s work is of a medical administrative nature: furthering the training of the Medical Assistants and RMAs, giving health and first aid lectures, making sure that the medical equipment G1098 and I1248 scales are correct and so on.

The problem within many units is the lack of medical supervision within the unit, and the object was then to persuade units to appoint an officer to take on this task; then to tell him what he should know. This officer was called the Unit Health Officer and his basic terms of reference is the Check List which is to be described.

The Unit Health Officer

Almost all units in Western District and Wales have now accepted the necessity of a permanent staff officer taking over the day to day medical administration. He is usually the Adjutant, in some cases the Quartermaster, and in a few a senior NCO. The Unit Health Officer acts as a permanent auditor of the unit health state as outlined in the Check List. However, in presenting his audit to his commanding officer, he automatically assumes the responsibility of executor as well. For having identified weaknesses, it then naturally falls to him to provide or suggest remedies in anticipation of his commanding officer’s questions. In this way units are learning to look after themselves better. It also encourages them to seek help from the medical branch at headquarters if they are unable to overcome difficulties. Informal follow up advisory visits by the staff from the medical branch have shown that commanding officers are happy to know what they should be aware of medically. They have also shown that commanding officers have become much more medically interested. Cooperation with the Unit Health Officers has been excellent after a few initial differences had been resolved. These problems were almost all the result of not fully understanding the point of some of the details given on the Check List. Discussions with unit RMOs have not revealed any conflict to have arisen between them and the Unit Health Officer as a result of his new role. Most medical officers are glad not to have

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to worry about doing the paperwork involved in unit medical administration.

The Check List
This is shown in the Table; it is pointed out that references are given, thus saving time during advisory visits in searching for "authorities" to back up statements made. The phraseology of the Check List is also such as to emphasise weaknesses rather than strengths.

The implication is that if there is a deficiency, the question which follows is: "What is being done about it?" This negative thinking was not easily understood in all instances; and resource had to be made to analogies such as the near efficiency of a landrover which, though having 75% of its wheels available, still could not be said to be battle-worthy. However, with the relatively high annual personnel turnover rate in the TA, a certain level of deficiencies was inevitable and acceptable.

During visits to the units certain points came up frequently during conversation; these will now be mentioned and particular aspects discussed.

Immunisations
The difficulties here were entirely those of getting medical officer and soldier requiring immunisation together on the same training evening. If the unit announced that the medical officer was to complete outstanding procedures on an ensuing evening, it would be likely that all those men due would not find themselves able to attend on that occasion.

Immunisations are done on a hit or miss basis. The only way to achieve "hits" was to have an up to date vaccinations due register maintained by the Unit Chief Clerk. On the training evening the medical officer is in, the vaccinations register is checked against that evening’s attendance list, and those men due immunological procedures are presented to the medical officer. Pulheems reviews and outstanding bloodgroups are dealt with in the same manner. The most important point of which most units were unaware was that protection is only gained in a course of immunisations. Most units believed that TABT, polio and in the past smallpox, could all be "done" on the annual fortnights camp; there was frequent unawareness that the first TABT was simply a "primer" and provided little or no immunity, which was only acquired from a completed course.

Medical Mobilisation Equipment
Asking questions as put in the Check List, assumes a presumption that action is or has been taken, to carry out the actions implied in the questions. This has had the effect of stimulating quartermasters to bring 1 1298 up to scale, replace outdated stocks, and return to medical stores stocks which have still only a limited usefulness left. The Officer Commanding No 1 Medical Group, prepared and issued an advisory leaflet for all TA Quartermasters in the districts on how to inspect and indent for medical material.

Medical Training
Specific attention is paid to finding out whether Regimental Medical Assistants (RMAs) or Medical Assistants (MAs) are in fact available for their medical role in the unit. Senior NCOs, even though they may be qualified as MA or RMA, are not considered to be filling vacancies on the unit establishment, unless their primary role is medical. Attention is also given to establishing whether Medical Assistants are correctly distributed throughout the companies in a battalion. First Aid Training is only "advised" in the Army Training Directive where it concerns the Territorial Army. Most TA units now have annual training programmes which include first aid. It is generally very difficult though to find out how many soldiers have actually completed the first aid part of the programme. Units have been encouraged to conclude training with a test, and to make the company first aid instructor directly responsible for training all the men in his company. In order to obtain the unit’s guarantee of standards, efforts have been made to persuade units to publish lists of men who have passed an annual first aid test in Part I Orders.

Unit Health Training
Water duties, Hygiene and Pest Control are also only "advisory" for the TA under the terms of the Army Training Directive. This has meant that many units gave health training a low priority, and a number had no one trained in these skills. Once the value of men so trained has been related to a survival situation many units found themselves able to spare men to attend these courses. Maintaining the efficiency of trained men and of water testing equipment was complemented by the issue of an advisory sheet by the Environmental Health Officer HQ Western District.

Conclusion
The unit health audit as described puts the onus upon the unit itself for carrying out its own administration. Once explained that purely ‘A’ (medical) and ‘Q’ (medical) matters are being considered, unit officers appreciated the logic of the system. The audit generated its own dynamics: the officer responsible for health matters was obliged to initiate action to remedy deficiencies himself. The role of the CRAMC was to start the system and by visits to the units maintain its momentum.
**HEALTH CHECK LIST**

**Unit Health Officer (Advisory)**

1. An officer responsible for the day to day health administration in the unit.

2. **Medical Classification.** All soldiers must be medically examined (Mandatory)
   - (a) Number overdue Report Pulloems review .................................
   - (b) Number in unit below FE Grading ...........................................

3. **Blood Grouping (Mandatory)**
   - Number in unit not blood grouped ................................................

4. **Vaccinations (Mandatory)**
   - (a) Is the vaccination register up to date? ....................................
   - (b) Number of soldiers out of date ............................................... (1) Numbers unprotected against typhoid, paratyphoid and tetanus (TABT).
   - (2) Numbers unprotected against Tetanus .................................
   - (3) Numbers unprotected against poliomyelitis ...........................

5. **Med Mob Equipment**
   - (a) When was the last quarterly med mob equip check? ....................
   - (b) Have all out of date drugs been replaced? ..............................
   - (c) Where is the unit AFG 1098 scale of dangerous drugs kept .......
     - (1) Who maintains the register .............................................
     - (2) When was the last monthly check made ............................

6. **Regimental Medical Staff**
   - (a) Number of qualified RMA/MA .............................................
   - (b) How many cannot drive their LR ambulances? .........................
   - (c) How many have still to achieve RMA/MA Class 1? ...................

7. **Regimental First Aid Training (Advisory)**
   - Object to save life:
     - (a) **Number of First Aid Instructors** advised 1 per company and a 50% reserve in the unit.
     - (b) **Number of men** who have not undergone first aid training/retraining and testing in the past year.
     - (c) Do company First Aid Instructors maintain their own first aid training and testing record? ...........................

8. **Regimental Health Training (Advisory)**
   - Object to survive, in war when public water and health facilities break down.
     - (a) **Water duties trained** number below that recommended .....
     - (b) **Hygiene and pest control** trained number below that recommended ...........................

9. **Unit Health Training (Advisory)**
   - Training to be carried out by RMO or Unit Hygiene Instructor. Which Serials in Appendix I have not been carried out in the past year?

10. **Respirator Spectacles (Mandatory)**
    - For those who need glasses to shoot, drive and read.
    - Number of men needing them who do not yet possess Mark 5 spectacles ....

11. **Hearing Protection (Mandatory)**
    - Deafness resulting from loud noises is cumulative, progressive and permanent.
    - (a) Number of men not yet issued with V51A ear defenders ..........................
    - (b) Are unit orders regularly promulgated on the subject of avoidance of hearing damage? ..........................
    - (c) Have all special risk category soldiers been identified? ...................

12. **Food Handlers (Mandatory)**
    - Food poisoning is common debilitating and sometimes fatal.
    - (a) Have all food handlers received medical clearance prior to their employment? ..........................
    - (b) Do they continue to meet the required standards in health and personal hygiene? ..........................

13. **Medical Documentation (Mandatory)**
    - (a) How many ID cards are not yet stamped with the blood group? ...........
    - (b) How many ID discs are not yet stamped with the blood group? ...........
    - (c) How many entitled personnel have not yet got Geneva convention cards? ...........
    - (d) Where are offrs and sldrs med docs (F Med 4) kept? ...................
    - (e) How many are deficient? .....................................................
    - How many have not yet had chaser action started? ..........................

14. **Health and Safety at Work Act (Mandatory)**
    - (a) Who is the Unit Safety Officer? ............................................
    - (b) When did he attend the safety officers course? .........................
    - (c) Is he complying with the recommendations in AGAI Vol 3? ...........

**Reference**

- MOD ltr D/AMD/65/615 (AMD5) of 260280
- Army 282/80
- AGAI Vol 2
- Chap 66.132
- AGAI Vol 2
- Chap 66.017 to 935
- AFG 10 11298
- ATD No 5
- ATD 2 & 5
- ATD 2 s7
- ATD 2 s6
- ATD 2 s6
- ATD 5 Annex A
- ATD 5 Annex B
- AGAI Vol 2
- AGAI Vol 2
- Chap 66331-370
- AGAI Vol 2
- Chap 66.391-406
- UDM para 324
- UDM para 136
- UDM para 133
- UDM para 302
- UDM para 307
- AGAI Vol 3
- Ch 99.001.074
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