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Assessing operational readiness of the Australian Army's Health Capability

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ABSTRACT

A key role for the Operational Health Advisers in the Australian Defence Forces is to provide advice to their respective Commanders on the preparedness for operations of the health assets assigned to them. From an Army perspective, other Corps and Unit types have a defined process to assess this.

There is no defined method of determining the preparedness of Army health elements to undertake their operational role.

The components that contribute to the assessment of preparedness to provide Army operational health support are:

- Individual and collective preparedness for military service in an operational environment
- Individual skills, knowledge and attributes to perform professional and trade tasks
- Ability of the health capability team to perform the tasks expected of the team.

The individual and collective assessment for military service on operations is covered by extant Army policy and procedures.

The assessment of individuals and health capability teams to undertake their health-specific duties is not performed in a structured or comprehensive manner.

In the civilian health care environment, the equivalent processes include:

- Credentialing of health care providers
- Accreditation processes
- Health service audits.

These activities need to be undertaken in a systematic way so health advisers at all levels can be comfortable when they tell their Commanders that the health capability assigned to them is ready to provide operational health support. It is suggested that this system would include:

- Compliance with extant currency and credentialing requirements.

- The introduction and application of a competency-based logbook where an individual's experience is documented and this contributes to the assessment of the individual's readiness.
- A comprehensive accreditation process that allows the comparison of a health capability team against a benchmark standard for training, equipment and experience.
- A process that includes an external review of the performance of a health capability under simulated conditions as well as appropriate chart reviews of actual care provided.

The details of such a system should be developed in conjunction with the range of trades and professions and trialed in exercises over the coming 12 to 24 months.

INTRODUCTION

The combat units of the Australian Army have relatively well defined measures of their readiness for operations. Infantry units prior to their deployment to East Timor are assessed by the Land Command Battle School's Combat Training Centre in a series of test scenarios designed to confirm they have reached a minimum acceptable level of operational proficiency. Artillery units have long been assessed through the artillery chain of command using the Army Training and Evaluation Programs (ARTEPS) process. Armoured units have a graded series of range practices that ensures their sub elements are capable or operating in the tactical environment. There is no formal system in place to provide this same assessment for the health capability of the Australian Army.

AIM

The aim of this paper is propose a system for assessing the operational readiness of the Australian Army health capability.

PURPOSE

The purposes of a system for assessing the operational readiness of the Army's health capability are envisaged to include:

- Providing a system to allow Commanders from platoon to Unit level to consistently assess the status of their health capability.
- Providing a system to allow Formation and above health staff to assess health elements in order to provide advice to their Commander on the operational readiness of the health capability.

At Unit and below level, this assessment could be used to assist the planning of training programs. At Formation and Force level, these assessments will help discharge the clinical governance function of senior health officers.

COMPONENTS OF HEALTH READINESS

The Land Warfare Doctrine Centre's Doctrine Wing describes 'readiness' as:

'Readiness denotes a force's ability to be committed to operations within a specified time. Readiness refers to availability and proficiency of personnel and availability and serviceability of equipment, facilities and consumables.'

This leads operational health readiness to being broken down into the following components:

- Individual military skills proficiency
- Individual health specific skills, knowledge and attitudes

- Collective ability of health elements to undertake their assigned tasks.

The assessment of individual military skills proficiency, such as weapon handling and field craft, will not be explored in this paper. They are well covered in extant instructions such as the Army Individual Readiness Notice¹

INDIVIDUAL ASPECTS

The Australian Council for Safety and Quality in Health Care defines 'credentials' as:

The qualifications, professional training, clinical experience, and training and experience in leadership, research, education, communication and teamwork that contribute to a medical practitioner's competence, performance and professional suitability to provide safe, high quality health care services²

They define 'competence' as:

The demonstrated ability to provide health care services at an expected level of safety and quality³

The Defence Health Policy Directive Number 8224 deals with the assessment of currency and competency of health employment categories and qualifications. For medical and dental officers the implementation of competency based career structures will include some level of review of basic credentials for practice. This system will not include specific credentialing for procedures or cover their scope of practice. These issues are organisation specific. A health directive covering the scope of practice for ADF Nursing Officers is under development (personal discussion with Land Headquarters Staff). For other health professions, the ADF tends to rely on recognition by the relevant professional bodies to accept the qualifications of disciplines such as physiotherapy, pharmacy, radiology and pathology as a minimum standard for ADF service.

For the health trades (medical assistants, operating theatre technicians, pathology technicians and others), the Army relies on the initial employment training to provide the skills, knowledge and attitudes required. There have been moves over the years to introduce competency based log books to record experiential training and as an aid to document currency in skill taught, however this approach has not been completely adopted as yet.

For the purposes of determining the operational readiness of an individual to perform the health specific tasks of their position, there are two elements:

The underlying formal education and training required. This equates to the credentialing and competency processes referred to above.

The experiential training that builds on the formal education and builds on this to enable the health care provider to cope in the operational environment.

The underlying formal education of individuals is relatively easy to determine. An individual's personal file should contain evidence of the formal qualifications held, including military health trade courses.

It is more problematic to set the minimum standards for experiential training and currency requirements for skills and procedures. For example, medical assistants were trained to insert

peripheral venous lines on what was known as the advanced assistant medical course. This skill is now trained on the advanced medical assistant course or an advanced module after the end of the basic medical assistant course. Irrespective of when the skill was trained, how should this skill be maintained? There are no universally accepted standards of how often an individual should insert a peripheral line to be deemed competent at a point in time to do perform this procedure, and of course even the most experienced operator may not successfully establish a line in a given patient at a given time.

Accepting that standards cannot be defined to this level, experiential training following gaining formal qualifications is still a valuable component of being prepared for employment on operations. The nature of the experience gained following education should prepare the individual for operations. The nature of this experience will vary with the profession. For medical and dental officers, the assessment of competencies includes an experiential component such as the participation in relevant continuing education programs. For other groups, mission critical tasks should form the basis to assess individual readiness. These tasks would be determined on the basis of the more challenging tasks that might be required in the operational environment. For example:

- Nursing officers who will be assigned to work in deployed operating theatres should have experience in working in an emergency theatre situation.
- Scientific officers and pathology technicians should have experience in undertaking cross matching procedures.
- Radiologists should have experience in the radiology of patients with multi system trauma.
- Medical assistants should have experience in resuscitating patients with multi system trauma.

This list is not meant to be exhaustive. Each health trade or profession would need to have a range of experience identified as providing the requisite experience.

COLLECTIVE ASPECTS

The closest equivalent to the assessment of a team's operational readiness in the non-military environment is arguably the accreditation process. Health services accreditation is generally seen to be a system of self regulation of health services involving an independent agency defining and monitoring standards for the participants in the scheme⁶. This process is widely implemented around the world, with the number of programs around the world doubling every five years since 1997. Hurst⁸ ascribes some of this popularity to the quality assurance movement in health care.

Accreditation should not be seen as the 'be all and end all', with questions being raised about benefits that come from the process. Shaw⁹ discusses the accreditation leading to improvements in organisational processes but little evidence of benefits in terms of outcomes and clinical processes. An approach to assessing operational readiness based on the accreditation process would seem to be a reasonable starting point.

The JP 2060 Concept has identified health capability teams as the smallest elements that can provide an operational capability. Implied in the term 'team' is that the capability of the team is more than the sum of the individual members. This notion of the value of the collective effort can be extended to the contribution of each of the teams to the output of sub units and units.

Given the nature of military health support, including the frequent changes to personnel and the integration of reserve members and teams into the structure, Army health capability teams are not static, nor would these be an achievable goal to set for a unit. Some of the general military training is

aimed at providing individuals with the skills to move in and out of teams quickly and individuals who can 'pull together' a small group into an effective team quickly will tend to be identified as potential leaders.

Assessment of the operational readiness of health capability will need to involve consideration of how well the component teams work from a team specific perspective as well as their contribution to sub unit and unit performance.

It is suggested there should be two phases to the collective assessment:

A process and document review. This would include reviewing standard operating procedures for completeness and any other relevant documentation such as ward standing orders and clinical guidelines. If the assessment is being done in the context of an exercise or operation, the relevant orders and instructions would form part of this phase.

An observation phase. In this phase, the health element is observed in the deployed environment. People with relevant background and experience compared to the elements being observed would conduct this stage. The element could be observed conducting their normal training program or specific 'assessment scenarios' could be injected into the exercise to assess selected aspects. For example, the requirement for the environmental health team to conduct vector control activities could be initiated through exercise play, as could a mass casualty scenario. This phase would require co-operation and co-ordination between the assessing team and the exercise directing staff.

OUTLINE CONCEPT OF ASSESSMENT SYSTEM

The proposed system for the assessment of the operational readiness of health capability elements could be applied to any health capability element, including elements in a non health services unit such as a battalion regimental aid post. The system has three elements:

Credentials and Experience Check: Confirmation of the individual skills, knowledge and attitudes of the personnel, compared to the requirements of the position they are posted against. This would include a review of the formal qualifications and credential held as well as a review of competency log books and records of any experience related to strategic alliances.

Process and Document Check: A process and document review of relevant documents such as standard operating procedures, orders and instructions, clinical guidelines and health policy and doctrine.

Direct Observation: A 'survey' of the element providing health services in the deployed environment. This is akin to the Australian Council of Health Care Standards (ACHS- see <http://www.achs.org.au/>) accreditation process. An internal survey could be conducted by Commanders using organic resources to allow training needs to be identified and deficiencies in personnel to be quantified.

Senior headquarters should mandate this process and facilitate the provision of external surveyors as part of pre-deployment work up and at regular intervals in negotiation with formation headquarters. There would be a set of core criteria and elements for each component, with additional details tailored to the unit and the operational environment as appropriate. A key issue to be determined would be whether to contract out such a review process (perhaps to the ACHS) or to use ADF resources.

CONCLUSION

The setting of standards and monitoring performance is a key task of the health staff. The system proposed would allow the operational readiness of health capability elements to be assessed in a consistent and reliable manner. Although a system where the accreditation process would be compulsory is proposed, the intention remains educational and developmental rather than punitive¹⁰ (Hurst, 1997, p94). This would allow the process to inform training programs as well as provide an assessment of the operational readiness of the elements concerned.

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