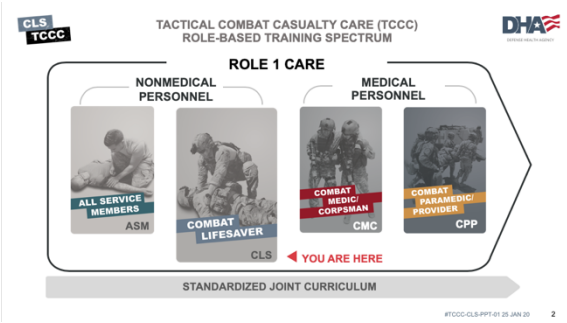
MODULE 04 – PRINCIPLES AND APPLICATION OF TFC

SLIDE 1 – TITLE SLIDE

SLIDE 2 – TCCC ROLES



Tactical Combat Casualty Care is broken up into four roles of care. The most basic is taught to All Service Members (ASM), which is designed to instruct in the absolute basics of hemorrhage control a nd to recognize more serious injuries.

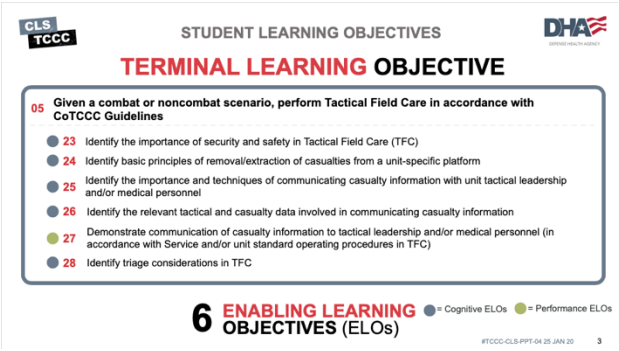
You are in the Combat Lifesaver (CLS) role. This teaches you more advanced care to treat the most common causes of death on the battlefield, and to recognize, prevent, and communicate with medical personnel the life-threatening complications of these injuries.

The Combat Medic/Corpsman (CMC) role includes much more advanced and invasive care requiring significantly more medical knowledge and skills.

Finally, the last role, Combat Paramedic/Provider (CPP) is for Combat paramedics and advanced providers, to provide the most sophisticated care to keep our wounded warriors alive and get them to definitive care.

Your role as a CLS is to treat the most common causes of death on the battlefield, which are massive hemorrhage and airway/respiratory problems. Also, you are given the skills to prevent complications and treat other associated but not immediately life-threatening injuries.

SLIDE 3 – TLO/ELO



Principles and Applications of Tactical Field Care module has five cognitive learning objectives and one performance learning objective. The cognitive learning objectives are to identify:

1. The importance of security and safety in Tactical Field Care

2. Basic principles of removal/extraction of casualties from a unit-specific platform

3. The importance and techniques of communicating casualty information with unit tactical leadership and/or medical personnel

4. The relevant tactical and casualty data involved in communicating casualty information, and identify triage considerations in Tactical Field Care

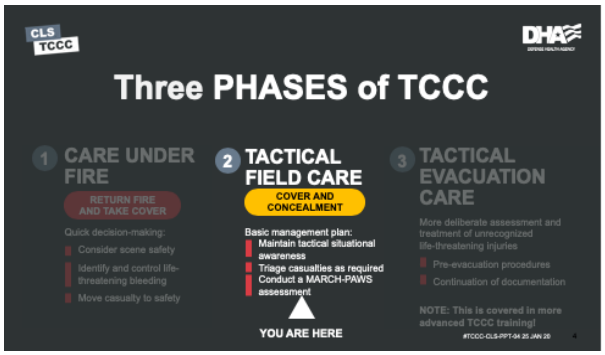
The performance learning objective is to demonstrate communication of casualty information to tactical leadership and/or medical personnel (in accordance with Service and/or unit standard operating procedures in TFC).

It is critical to identify the importance of maintaining situational awareness during TFC, as the tactical situation is fluid and may revert to CUF at any time.

SLIDE 4 – THREE PHASES OF TCCC

TFC is the second of three phases of TCCC.

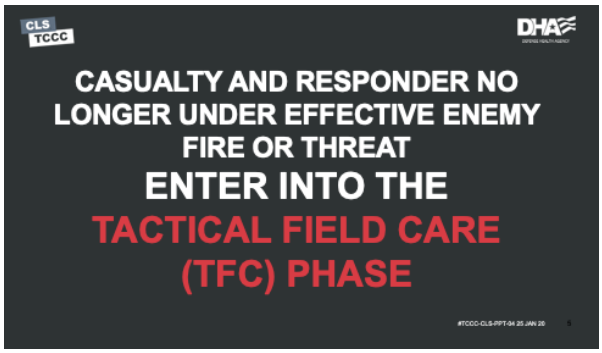
It is the care provided once the responder and casualty are no longer under direct threat from effective enemy fire.



SLIDE 5 – CASUALTY AND RESPONDER NO LONGER UNDER EFFECTIVE ENEMY FIRE OR THREAT

TFC is the care rendered by a first responder/CLS once the responder and casualty are no longer under direct threat from effective enemy fire.

This allows for the time and the relative safety for a more deliberate approach to casualty assessment and treatment.

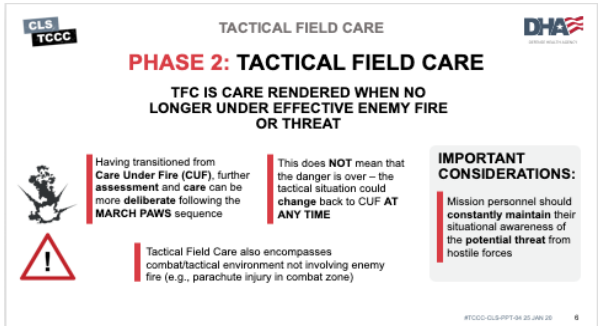


SLIDE 6 – PHASE 2: TACTICAL FIELD CARE

Casualty assessment and management in TFC follows a more deliberate approach known as MARCH PAWS:

Massive bleeding
Airway
Respiration/breathing
Circulation
Hypothermia/**H**ead Injuries

Pain
Antibiotics
Wounds
Splinting



This is a helpful pneumonic for remembering how to systematically approach casualty assessment and management, ensuring that life-threatening injuries are identified and treated promptly to save lives on the battlefield and reduce preventable combat deaths.

Keep in mind, even when you are in the TFC phase, it does not mean that the danger is over. The tactical situation could change back to CUF again at any time. CLSs must maintain security and situational awareness while continuing the assessment, treatment, and preparation of casualties for handoff to medical personnel/evacuation while remaining prepared to engage the enemy and continue the unit mission at any time.

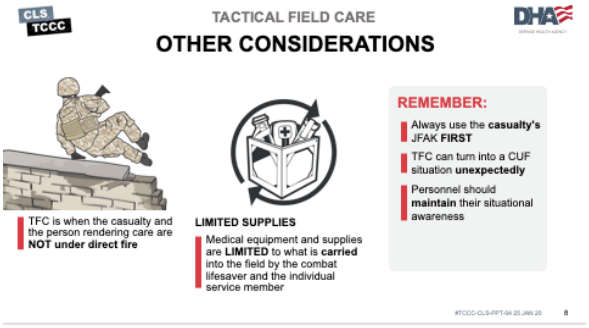
SLIDE 7 – SECURITY AND SAFETY IN TACTICAL FIELD CARE

Establish a security perimeter in accordance with unit tactical standard operating procedures and/or battle drills.

Maintain tactical situational awareness. Casualties with altered mental status should be disarmed, have communications secured, and have sensitive items redistributed.

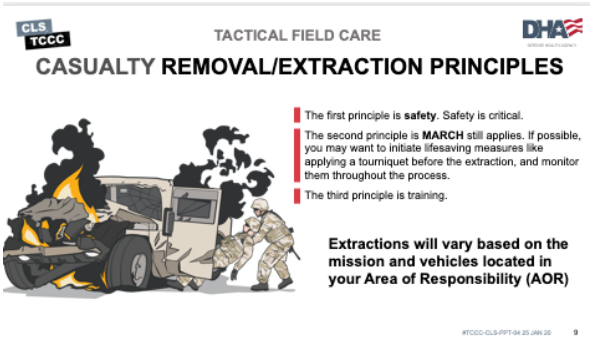
SLIDE 8 – OTHER CONSIDERATIONS OF TACTICAL FIELD CARE

In TFC, medical equipment that is available will be limited to that carried into the field by the casualty (their JFAK), the first responder/CLS (JFAK or unit combat lifesaver bag), or a responding medic (aid bag, etc.). Remember, whenever possible, use the casualty's JFAK supplies first.



SLIDE 9 – CASUALTY REMOVAL/EXTRACTION PRINCIPLES

Although the types of extractions you may encounter will vary based on your unit mission and the vehicles you use or locations you encounter, a couple of principles have universal application and can apply to most extraction situations.



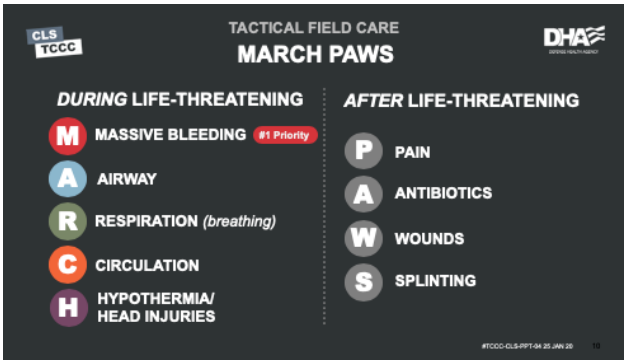
The first principle is safety. The worst outcome would be to have additional casualties during an extraction attempt, and almost all extraction scenarios have some compromised safety; whether that is from fires at the removal site, vehicle rollovers that are unstable, condemned buildings that are structurally compromised, or some other scene issues.

The second principle is that the concept of MARCH still applies, and the treatment priorities do not change because the casualty is in a position that is difficult to access. If lifesaving treatments like limb tourniquet application can be done before extraction, they should be completed and monitored throughout the extraction process. If the casualty is in a position where access to provide those treatments can't be accomplished, then they need to be moved as quickly as is safely possible. To that end, if a cervical spine injury might be suspected, the delay to immobilize the spine may lead to a bad outcome and shouldn't be prioritized over accessing the casualty to perform other lifesaving interventions.

The third principle is that is it important to spend time training, before deployments and during deployments, on how to extract and remove casualties from the unit assets and tactical environments that you are most likely to encounter while performing your unit mission. The unit medical team may organize these, but as a combat lifesaver it is also your responsibility to ensure the unit is properly trained to help support you if an extraction is needed.

SLIDE 10 – MARCH PAWS

When you are in Tactical Field Care, follow the MARCH PAWS sequence in assessing the casualty.



A full tactical trauma assessment should follow the MARCH PAWS sequence.

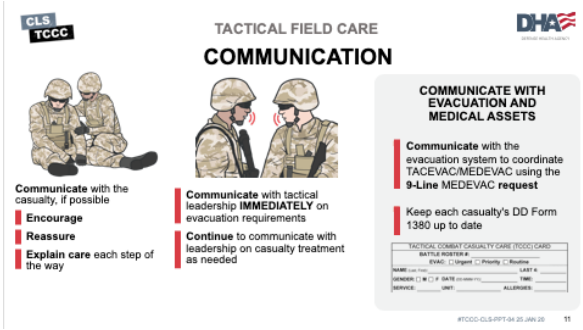
- **M**assive bleeding
- **A**irway
- **R**espiration/breathing
- **C**irculation
- **H**ypothermia/**H**ead injuries

- **P**ain
- **A**ntibiotics
- **W**ounds
- **S**plinting

SLIDE 11 – COMMUNICATION

CLSs will continue treatment **until handoff** with medical personnel and should communicate with:

1. The casualty throughout assessment and treatment
2. Tactical leadership about casualty status and evacuation requirements
3. The evacuation system (TACEVAC), including 9-line MEDEVAC request/MIST
4. Medical providers about casualty assessment and treatment (DD Form 1380)



Communicate with the casualty throughout care. Being physically wounded may generate significant anxiety and fear above and beyond the psychological trauma of combat. Talking frankly with the casualty about their injuries and offering reassurance by describing the treatments being rendered and emphasizing that everything possible is being done on their behalf and that they will be well taken care of will help to counter their anxiety. **Be honest about the injuries sustained** but maintain a positive

attitude about rescue and treatment. Talking with the casualty helps assess their mental status, while talking through procedures helps maintain your own confidence and the casualty's confidence in you.

Communicate with tactical leadership ASAP and throughout casualty treatment. Tactical leadership needs to understand the impact on the mission. For example, tactical leadership may need to know:

- How many casualties were inflicted?
- Who is down as a casualty?
- Can the casualty still fight?
- Has the enemy threat been eliminated?
- Are weapons systems down or fields of fire not covered because the unit has taken casualties?
- Is it necessary to have others fill in the casualties fighting positions? Or do the casualties need to be moved?

Communicate with the evacuation coordination cell to arrange for TACEVAC. Communicate with medical providers about details of the casualty injuries. This includes 9-line communication and ongoing MIST reports.

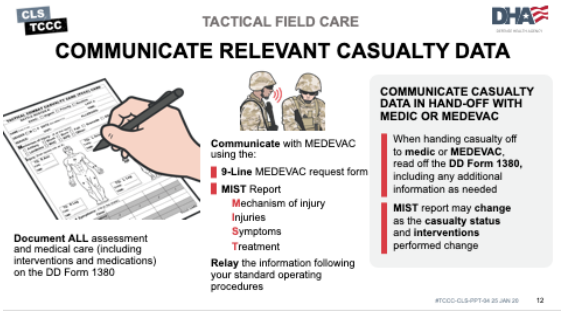
Medical leadership may need to know:

- What injuries were sustained?
- What is the mental and physical status of each casualty?
- What treatments were needed and rendered?
- Does the medic need to triage multiple casualties?
- Should the medic move to a casualty, or should the casualty be moved to the medic?
- Are there enough Class VIII medical supplies?
- Does the unit need to break out litters or extraction equipment?

SLIDE 12 – COMMUNICATE RELEVANT CASUALTY DATA

Document all assessment and care provided (including medications and interventions) on the DD Form 1380.

Communicate with MEDEVAC using a **9-line** MEDEVAC request and **MIST Report**.

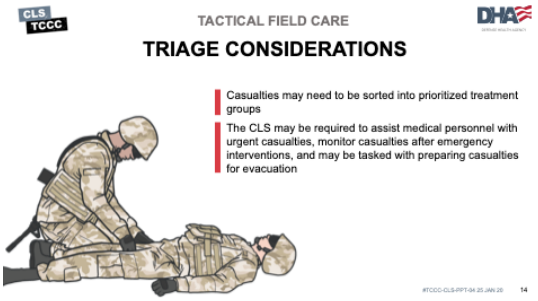


SLIDE 13 – TRIAGE – PRIORITIZING MULTIPLE CASUALTIES

CLS should consider these priorities (following MARCH) to decide how to prioritize treatment of multiple casualties in the TFC phase of care:

#1 Massive bleeding
#2 Penetrating trauma
#3 Airway
#4 Respiratory distress
#5 Altered mental status

SLIDE 14 – TRIAGE CONSIDERATIONS

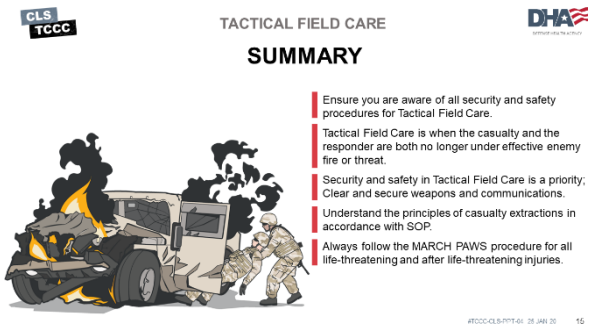


"Triage Considerations" means casualties may need to be sorted into prioritized treatment groups.

The CLS may be required to assist medical personnel with urgent casualties.

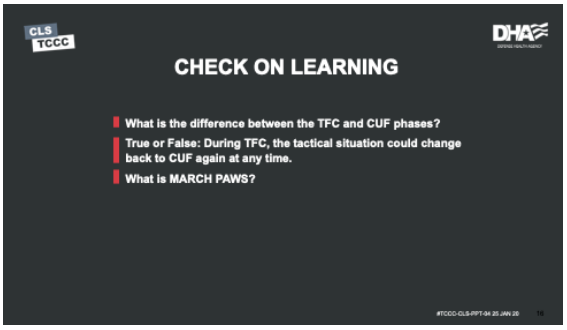
The CLS may be assigned to monitor casualties after emergency interventions; the CLS may be tasked with preparing casualties for evacuation.

SLIDE 15 – Summary



In this module, we discussed the principles and applications of TFC, emphasizing the need to maintain situation awareness. We identified the importance of security and safety in TFC, the basic principles of casualty removal and extraction from a unit-specific platform, techniques for communicating casualty information with unit tactical leadership and medical personnel, relevant tactical and casualty data involved in communicating casualty information, and triage considerations.

SLIDE 16 – CHECK ON LEARNING



Ask questions of the learners referring to key concepts from the module.

Now for a check on learning:

Slide 13

1) What is the difference between the TFC and CUF phases?
   - TFC is distinguished from CUF by a reduced level of threat from hostile fire (the shooting has stopped – or enemy fire is ineffective), and relatively more time available to provide care, depending on the tactical situation and available medical equipment (still limited but often includes additional equipment carried in the CLS bag, medic bags, or in medical kits in tactical vehicles).
2) True or False: During TFC, the tactical situation could change back to CUF, again at any time.
   - True
3) What is MARCH PAWS?
   - The MARCH PAWS sequence is the pneumonic for TCCC assessment and treatment of casualties, which enables systematic identification and intervention of life-threatening injuries that could result in preventable combat deaths.

SLIDE 17 – QUESTIONS