

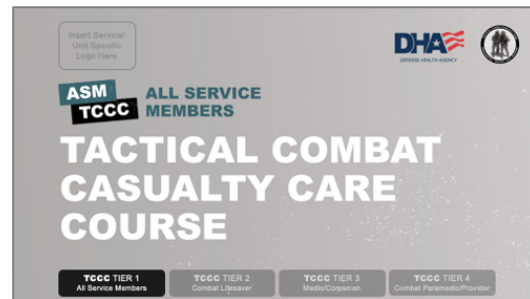
These comprehensive speaker notes provide a script for the trainer to use during the delivery of the TCCC-ASM Didactic Presentation. The notes also include key points that should be emphasized throughout the presentation.

SPEAKER NOTES

SLIDE 1: TITLE SLIDE

No particular narrative for this slide.

Suggestion: Delay course welcome and introductory details until after playing the opening video.



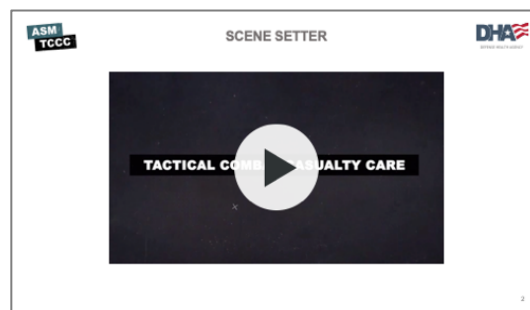
SLIDE 2: TCCC INTRO VIDEO (CLICK PLAY)

The course starts by playing a motivational video or scene setter to launch the course.

Immediately after the video ends, this could be an opportunity for a brief but impactful interactive exercise with the students.

Optional teaching activity to help reinforce the “so what” of TCCC training.

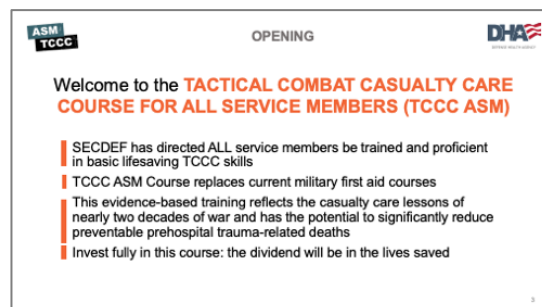
Action: Everyone please stand. Ask 24% of the audience to remain standing (about 1/4) and ask others to sit down.



Statement: Those that are still standing have unfortunately died. These are your buddies whose lives could have been saved had TCCC been implemented. *(Pause)* Thank you. Please be seated.

SLIDE 3: Welcome to the TACTICAL COMBAT CASUALTY CARE (TCCC) ALL SERVICE MEMBERS

Good morning, and welcome to the Tactical Combat Casualty Care Course for ALL Service Members. My name is (insert), and I am the lead trainer for this course. I am joined by other trainers who will lead hands-on training. *(Introduce others as appropriate.)*



The Secretary of Defense has directed that ALL military Service members be trained and become proficient in basic lifesaving TCCC skills or what we call TCCC.

TCCC ASM Course replaces current military first aid courses. This evidence-based training reflects the casualty care lessons of nearly two decades of war and has the potential to significantly reduce preventable, prehospital trauma-related deaths. You are here to learn and become proficient in the TCCC course materials and skills. If you invest fully in this course, the dividend paid will be in the lives saved.

NOTES:

SLIDE 4: CENTRAL OBJECTIVE

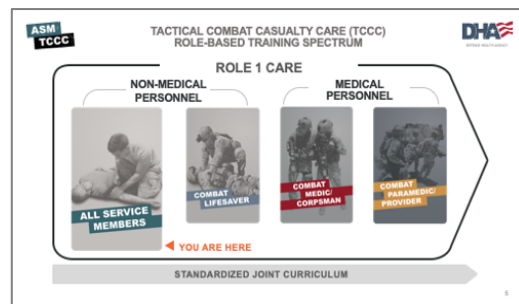
By the end of this course you will know the fundamental concepts and be able to perform five lifesaving skills at a basic proficiency level.

CENTRAL OBJECTIVE

By the end of this course,
you will know the fundamental concepts of
TACTICAL COMBAT CASUALTY CARE
 and be able to perform
5 LIFESAVING SKILLS
 at a *basic competency* level.

SLIDE 5: SPECTRUM OF TCCC TRAINING

TCCC training is divided into four levels, the first being ASM/basic casualty care for all Service members, and progressing to more advanced training for medical personnel. Today, we are concentrating on ASM training focused on basic proficiency.



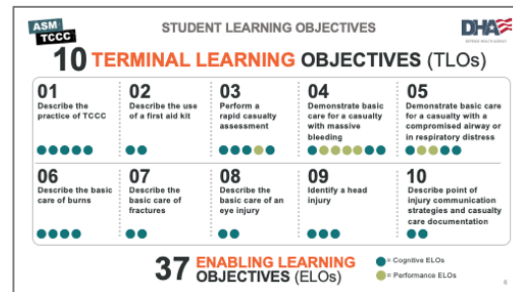
Depending on your duty assignment in the past/future, you may receive Combat Lifesaver (CLS) or you may have already had some form of CLS as part of prior medical training. If this is the case, just know that we are focused only on the ASM Course today. The ultimate goal is to ensure that everyone across the joint forces is trained in TCCC.

Trainer Note: ASM versus CLS. Depending on your service, it's possible that you will have a class that has personnel with varied experiences—from no prior TCCC training to TCCC All Combatants (TCCC AC) or Combat Lifesaver (TCCC CLS). In the case where there are students with prior exposure, it's important that you reorient them to the ASM level that is being trained.

NOTES:

SLIDE 6: LEARNING OBJECTIVES

(Students need to understand the basis for the course, and the expected learning outcomes). The TCCC ASM course is built on a foundation of learning objectives. These objectives lay out the structure for your learning experience, and make it clear what knowledge and skills you can expect to acquire by the end of the course.



There are 10 Terminal Learning Objectives or TLOs. Each TLO is supported by a series of Enabling Learning Objectives or ELOs.

In this graphic, we provided a quick visual way for you to easily see how these ELOs are mapped to the TLOs. The blue dots are cognitive or knowledge learning objectives, and the green dots are performance objectives focused on skills. Using this approach, you can quickly see where the emphasis on learning lies. The more dots, the more emphasis. You should be able to notice right away that TLO 1, 3, 4, and 5 are the priority with the main emphasis on bleeding control.

Trainer quick reference:

1. Describe the practice of TCCC.
2. Describe the use of a first aid kit.
3. Perform a rapid casualty assessment.
4. Demonstrate basic care of a casualty with massive bleeding.
5. Demonstrate basic care of a casualty with a compromised airway or respiratory distress.
6. Describe the basic care of a casualty with burns.
7. Describe the basic care of a casualty with a fracture.
8. Describe the basic care of a casualty with an eye injury.
9. Identify a casualty with a head injury.
10. Describe point of injury communication strategies and casualty care documentation.

NOTES:

SLIDE 7: LIFESAVING SKILLS

It is known that up to 28% of combat deaths and 20% of civilian trauma deaths are potentially preventable with optimal emergency and trauma care.

The lifesaving skills that you will learn during this course will prepare you to care for casualties at the point of injury and help to keep them alive long enough for help to arrive.

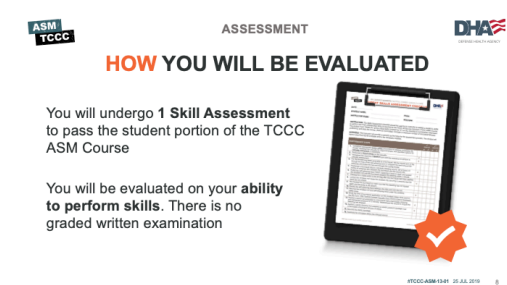
The five lifesaving skills you will learn are: rapid casualty assessment, tourniquet application, wound packing with a hemostatic dressing, application of a pressure bandage, and basic airway maneuvers to open the airway.



NOTES:

SLIDE 8: HOW YOU WILL BE EVALUATED

You will need to achieve a basic proficiency level in TCCC to pass this course. Each of you will undergo a formal evaluation. Your trainer will use the Skills Checklist to perform the evaluation. In order to pass the skills assessment, you must accurately complete all the steps marked as critical. There is no written examination for this course. The emphasis is on your ability to perform the skills.



NOTES:

SLIDE 9: 3 PHASES OF TCCC

TCCC is organized into **Phases of Care** that start at the point of injury. These phases are relevant to both combat and non-combat trauma scenarios.



1. **Care under Fire or Care Under Threat** is the aid rendered at the trauma scene while there is still an active threat. Available medical equipment is limited to that carried by an individual or found in a nearby first aid kit. Massive bleeding is the only medical priority that requires your attention during this phase, as you are actively dealing with what could be a chaotic and dangerous situation.

2. **Tactical Field Care** is the care provided once the threat has been neutralized and/or the scene is safe. During this phase a rapid casualty assessment should be performed. Bleeding control should be assessed/reassessed, and airway/breathing issues addressed. Other injuries such as burns, fractures, eye trauma, and head injuries should now be identified and cared for. Medical equipment is still limited. Time to arrival of medical personnel or evacuation may vary considerably, depending on the situation and location of the event.

3. **Tactical Evacuation Care** is the care rendered during and once the casualty has been moved by an aircraft or other transportation to a higher level of care. Additional medical personnel and equipment that may have been pre-staged or are co-located should be available in this phase of casualty management. This is not something that we cover at the ASM level, but we want you to be familiar with all the phases of care. The goal of TCCC is to give you a structured process by which to identify and care for casualties and help to keep them alive long enough to reach a medical treatment facility.

NOTES:

SLIDE 10: Phase 1 - CARE UNDER FIRE OR CARE UNDER THREAT

In Phase 1 or Care Under Fire (meaning combat scenario) or Care Under Threat, such as during a fire, industrial accident etc. the scene is often chaotic and there are many things that require your immediate attention, as you begin to approach a casualty.



There are four major areas for action: *(read all 4 first then go back to explain each one)*

1. Scene Safety
2. Casualty Movement
3. Control of any Massive Bleeding
4. Proper Communication

What you do first really depends on the scenario, but generally, scene safety is paramount. If the scene is safe, and there is massive life-threatening bleeding, your first step could be tourniquet placement. Each scenario is different, and the ordering of these actions could vary.

Scene Safety; First, you must ensure the scene is safe for you to enter. You can help others who may be working to secure the scene or you may have to do what you can to make the scene safe to enter (return gunfire, firefighting etc.). You can't risk your personal safety or the safety of your casualty.

You may need to move the casualty to a safer area due to a real or potential threat that exists in the environment. In that case, you must quickly develop a casualty movement plan that takes into account these important considerations: the location of the nearest cover, how best to move yourself or the casualty, the weight of the casualty, and the distance to be covered.

You should also be aware of environment threats in forming a plan such as; Enemy engagement, active shooters, fire, flood, smoke and toxic gas, energized circuits or other force protection threats when planning a move.

One person or two person drags and carries, or other appropriate movement techniques can be used depending on the availability of personnel and physical movement constraints present (e.g. wooded area, tanks, vehicles, ships, aircraft).

Special circumstances exist when moving casualties into or around different aircraft, vehicles and ships. You may be required to pull someone out of an aircraft or tank or go up and down ladders and stairways on ships. You should make sure you are familiar with the types of casualty movement specific to your location and circumstance. The following video will show the most common types of drags and carries.

In Care under Fire, consider placing one or more hasty tourniquets in a “high and tight” manner to an arm or leg to control massive life-threatening bleeding. This should be accomplished in **less than 1 minute**. If the casualty is conscious, you make direct the casualty to render self-aid and apply a tourniquet to him/herself, if they have one. Regardless, a tourniquet applied in the CUF/Threat phase must be re-evaluated in Tactical Field Care or Phase II.

Once you are able to reach the casualty safely and taken any other precautions, you must communicate with the casualty.

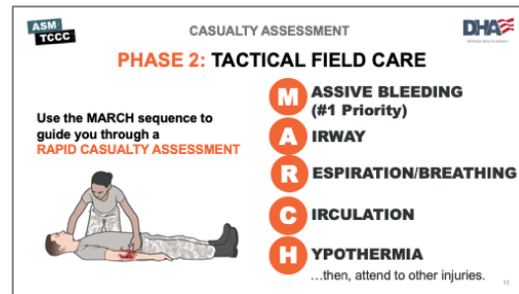
- **Responsiveness;** As soon as possible, maybe even before you have moved the casualty to a safe area, communicate with the casualty to determine if they are awake, confused or disoriented. If they are awake, let them know you are there to help.
- Request assistance from other first responders or medics, if available. Rarely are you alone in these circumstances.

[Play video clip on casualty movement)

SLIDE 11: PHASE II: TACTICAL FIELD CARE

In Phase 2, Tactical Field Care, it’s time to render medical aid.

You should initiate a rapid casualty assessment and render care based on your findings.



In TCCC, the treatment priorities follow the **MARCH** sequence. **MARCH** stands for: **(M)**assive Hemorrhage - Bleeding Control, **(A)**irway, **(R)**espiration/Breathing, **(C)**irculation, and **(H)**ypothermia.

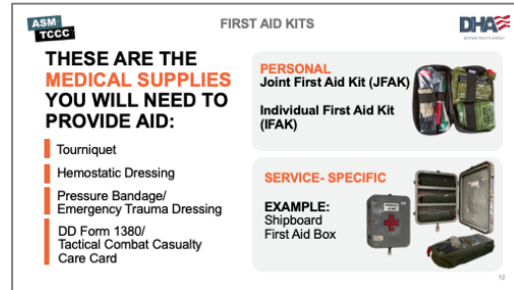
Once the MARCH priorities have been addressed, other injuries may be assessed and treated, including head injuries, eye trauma, fractures and burns.

MARCH is just not an acronym. These are the treatment priorities, with **M** *always being the most important*. This is not a linear process. If at any time massive bleeding is not controlled, go back to **M**.

NOTES:

SLIDE 12: FIRST AID KITS

The equipment and supplies you will need to provide medical aid in Tactical Field Care can be found in your personal or Service-specific first aid kit. It is important that you know the contents of these first aid kits, and where they are located, and understand any maintenance procedures for trauma supplies required by your unit.



For purposes of this course, you have been provided the following equipment for training

- Combat Application Tourniquet (CAT)
- Hemostatic Dressing
- Pressure Bandage/Emergency Trauma Dressing
- DD Form 1380 TCCC Card or other Service-specific card for documentation

Trainer Note: Consider providing more in-depth orientation to first aid kits based on unit level requirements.

NOTES:

SLIDE 13: MARCH - MASSIVE BLEEDING

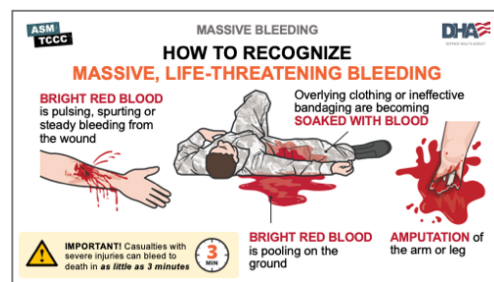
We are going to step through the **MARCH** sequence starting with “**M**” or Massive Bleeding.



SLIDE 14: HOW TO RECOGNIZE MASSIVE LIFE-THREATENING BLEEDING

Casualties with severe injuries can bleed to death in as little as 3 minutes. Signs of uncontrolled bleeding are:

1. There is pulsing or steady bleeding from the wound.
2. Blood is pooling on the ground.



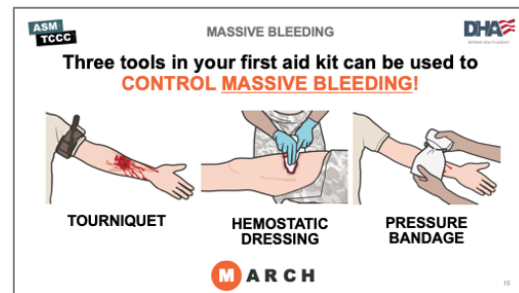
3. The overlying clothes are soaked with blood.
4. Bandages or makeshift bandages used to cover the wound are ineffective and steadily becoming soaked with blood.
5. There is an amputation of an arm or a leg.
6. There was prior bleeding, and the patient is now in shock (i.e., unconscious, confused, pale).

NOTES:

SLIDE 15: TOOLS to CONTROL MASSIVE BLEEDING

There are three supplies in your first aid kit that can be used to control bleeding:

1. CAT (tourniquet)
2. Hemostatic dressing
3. Pressure bandage



Hemostatic dressings and pressure bandages can be used to control bleeding from wounds in places where a tourniquet cannot be effectively applied, like the groin, arm pit, or the neck. Hemostatic dressings should be applied and direct, firm pressure held for three minutes.

Pressure dressings should be used to maintain hemostatic dressings in place; they help keep pressure applied to any source of active bleeding.

NOTES:

SLIDE 16: BASIC ORIENTATION TO A TOURNIQUET

There are different types of tourniquets, but the most common tourniquet in the military inventory is the Combat Application Tourniquet (CAT).

The CAT has several notable parts including:

- Windlass rod (used to twist and tighten the tourniquet)
- Windlass clip (used to secure the rod)
- Windlass safety strap (to keep the rod from becoming unsecured)
- Routing buckle (for routing the tourniquet band after it has been looped around an arm or a leg)



NOTES:

SLIDE 17: TOURNIQUET APPLICATION

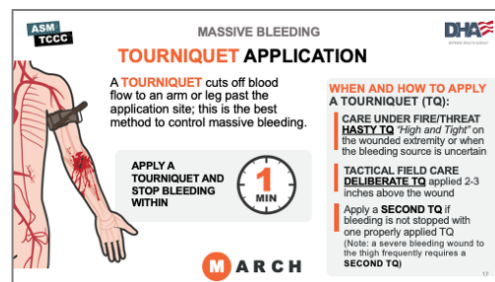
Let's review how a tourniquet works and when a tourniquet should be applied.

A tourniquet cuts off the flow of blood to the arm or leg past the application site and is the best method to control massive bleeding from an arm or a leg.

Tourniquets can be self-applied or applied to a casualty using either a one-handed or two-handed technique. These application techniques will be demonstrated and practiced at the skills stations. Self-application of a tourniquet might also save your life.

A tourniquet will hurt when applied correctly, because it must be tight enough to stop the blood flow.

Remember to tell the casualty that pain is expected and is an indicator that the tourniquet is being applied properly (tight enough). The application of a tourniquet to a massive bleed is time-sensitive! **The tourniquet should be applied to stop bleeding within 1 minute and be fully secured within 3 minutes.** A casualty with massive bleeding that is not controlled can die within 3 minutes!!!



Again, a hasty tourniquet is applied during Care Under Fire/Threat. This type of tourniquet is placed “high and tight” on a casualty’s extremity. *(The trainer may want to point to these locations on themselves to illustrate proper placement.)*

Once the casualty is in a safer position, you should reassess the source of bleeding and the effectiveness of the hasty tourniquet, and reapply if necessary, 2-3 inches above the wound. This is called a “deliberate tourniquet” since its placement is more targeted.

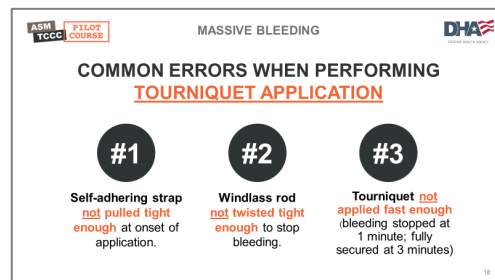
You may need to apply a second tourniquet, if the bleeding is not controlled. Severe bleeding to leg/thigh wounds frequently requires a second tourniquet.

Trainer Note: TQ duration: Optimal time is less than 2 hours (considered safe duration), after 3 hours, tissues begin to die. After 6 hours of application, limb loss can occur.

NOTES:

SLIDE 18: COMMON ERRORS when applying a tourniquet

1. The self-adhering strap is **NOT** pulled tight enough. There is slack in the strap.
2. The windlass rod is **NOT** twisted tight enough to stop the bleeding. *Note: It typically takes several twists to stop the bleeding.*
3. The tourniquet is **NOT** applied, and bleeding is NOT stopped within 1 minute.



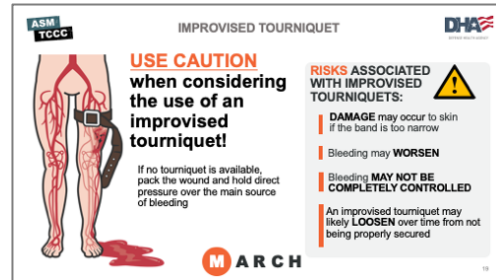
Tourniquets can loosen over time; keep a close eye on even after the tourniquet has been fully applied.

We will go over these and other issues at the hands-on skills training.

NOTES:

SLIDE 19: IMPROVISED TOURNIQUET

Using one of the CoTCCC recommended tourniquets is a safe procedure. Improvised tourniquets are much less effective than commercially available tourniquets such as the CAT, and they are difficult to make and apply without extensive practice.



Caution should always be used when using an improvised tourniquet due to the associated risks.

The risks include:

- damage to the skin if the band is too narrow
- it may worsen bleeding
- it may not completely control the bleeding
- like CAT tourniquets, improvised tourniquets can also loosen over time from not being properly secured

If a tourniquet is not available, pack the wound and hold direct pressure over the source of the heaviest bleed, FIRST. If this fails to control the bleeding in an arm or leg, only then consider an improvised tourniquet.

An improvised tourniquet uses other materials on hand. In constructing one, it is recommended that you roll or fold a cravat (or other fairly pliable material) to a width of approximately 1.5 – 2 inches and tighten it with some sort of windlass rod (a straight rod that can be used to twist the material tighter).

NOTES:

SLIDE 20 – WOUND PACKING AND PRESSURE BANDAGE

Depending on the type of injuries, you may also need to pack wounds and apply a pressure bandage. Wounds should be packed with a hemostatic dressing, which contains a special, chemical agent that promotes blood clotting. If you don't have access to a hemostatic dressing, you can use a clean cloth to pack wounds. Do not pack wounds to the chest or



abdomen. Remember, pressure is a form of treatment. In those cases, holding firm direct pressure will be the best option until a medic arrives.

Generally, you should apply a pressure bandage over a packed wound. Use short tugs as you wrap the bandage and continue to wrap using tension. Be careful not to wrap too tight and always check below the dressing to ensure the skin is still pink and warm to the touch. Ensure that a pulse is still present.

Trainer Note: ASM does not teach students to assess “capillary refill” when evaluating a pressure bandage. Instead use cool to the touch and pale skin as indicators of a pressure bandage that may be too tight.

NOTES:

SLIDE 21 MARCH - AIRWAY (A)

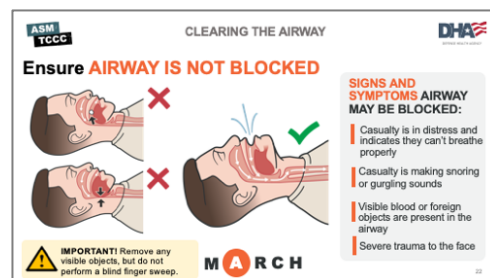
After Massive Bleeding is controlled, you move on to “A” in **MARCH** for Airway.



SLIDE 22: CLEARING THE AIRWAY

You must ensure a casualty’s airway is open. If they are awake and talking to you, this means their airway is open. However, the casualty may still have difficulty breathing.

If the casualty is unconscious, you need to inspect the airway for any obvious blockages.



The signs and symptoms of airway obstruction include:

- severe trauma to the face
- blood or foreign objects in the airway
- casualty is indicating that they can’t breathe
- casualty making snoring or gurgling sounds

If a foreign body is seen in the airway, you can attempt to remove it; but, do not put your fingers in the mouth to try to find or remove any unseen objects that might be causing an obstruction. **Do not do a blind finger sweep!**

NOTES:

SLIDE 23: AIRWAY MANEUVERS

In a casualty without a complete airway obstruction there are things you can do to assist with breathing, such as:

- perform a head-tilt/chin-lift or jaw-thrust maneuver
- place the casualty in the recovery position



You will learn how to perform these techniques along with the recovery position during the practical skill exercises. A jaw-thrust maneuver should be used if there is a suspected neck injury. For example, the casualty fell hitting their head on the ground.

A conscious casualty should be allowed to assume ANY position that allows them to breathe better. The best position may be sitting up. Generally, lying on the back is associated with a loss of airway patency when compared to other positions. If the casualty is unconscious but breathing, the casualty should be placed in the recovery position.

Trainer Note: Jaw-thrust tends to be over-emphasized in training and can be a distractor to the ASM audience. Try to minimize the occurrence of neck injuries in trauma to that pertaining to dramatic falls and motor vehicle accidents, etc. The reality is that most neck injuries occur on impact and what injury has been done is done. If there is neck trauma, it is likely they will do a jaw-thrust maneuver and hold that position until other personnel arrive to assist before continuing the MARCH sequence.

NOTES:

SLIDE 24: MARCH (R)

After the airway is open, you move to the “R” in **MARCH** to assess for Respiration and Breathing.



SLIDE 25: RESPIRATION & BREATHING

Exposure to smoke or toxic inhalants can cause difficulty breathing, but other injuries can also lead to respiratory distress.

Signs of respiratory distress include:

- difficulty breathing
- struggling to get air in and out
- breathing too weak to be effective (breathing less than 6 times per minute)
- rapid breathing (greater than 20 times per minute)

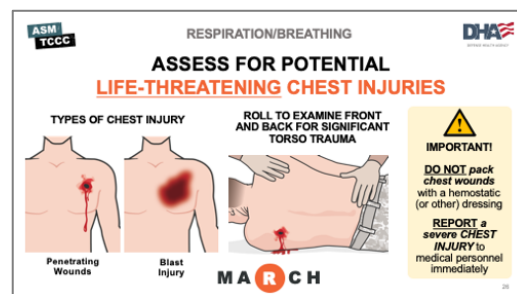


Casualties having a hard time breathing may also have penetrating chest wounds. It is critically important to report findings of RESPIRATORY DISTRESS to medical personnel at the scene.

NOTES:

SLIDE 26: LIFE-THREATENING CHEST INJURY

Life-threatening chest injuries can also result in respiratory distress. There are two types of chest injuries that can potentially be life threatening. Penetrating injuries, like those seen in gunshot wounds or shrapnel, or blunt trauma from blasts or vehicular accidents.



At this stage in MARCH, it’s time to roll the casualty to examine the front and back of the torso to check for chest trauma.

If you notice any holes, do not pack these chest wounds with a hemostatic or other dressing as highlighted earlier. Your role is to recognize that a casualty has a potentially life-threatening chest injury with respiratory distress and communicate those findings to responding medical personnel.

NOTES:

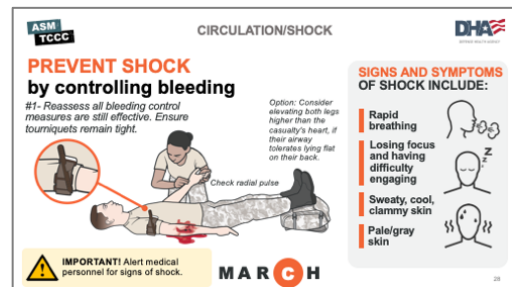
SLIDE 27: CIRCULATION

The “C” in **MARCH** is for Circulation, as you want to make sure your casualty has good blood flow throughout the body and is not going into a condition called “shock.”



SLIDE 28: CIRCULATION/SHOCK

The best way to prevent shock is to control bleeding! You should continuously monitor and reassess the effectiveness of bleeding control measures to ensure they are working: tourniquet application, wound packing with a hemostatic dressing and/or a pressure dressing or a combination of these.



The signs and symptoms of shock include:

- rapid breathing
- losing focus and having difficulty engaging
- having sweaty, cool, clammy skin, pale or gray skin.

In addition to these signs and symptoms, you can check for a weak or absent radial pulse. *Trainer Note: After reassessing TQs, the TCCC guideline on shock states: "Assess for hemorrhagic shock (altered mental status in the absence of brain injury and/or weak or absent radial pulse.)"*

NOTES:

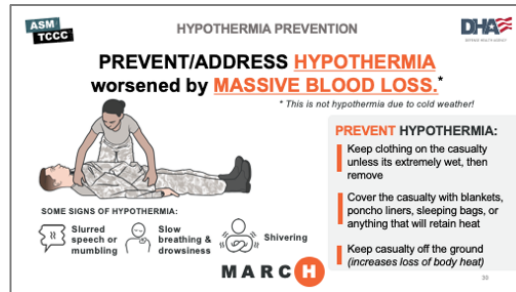
SLIDE 29: HYPOTHERMIA PREVENTION

Finally, the “H” is **MARCH** is for hypothermia prevention.



SLIDE 30: HYPOTHERMIA PREVENTION

Massive bleeding leads to hypothermia and, in turn, hypothermia leads to MORE bleeding because the blood cannot clot when the casualty is cold. This can occur even in hot environments. You must break this vicious cycle!



It is important to identify the signs of hypothermia. Some easily recognizable signs of hypothermia are: slurred speech or mumbling, slow breathing and drowsiness, and shivering.

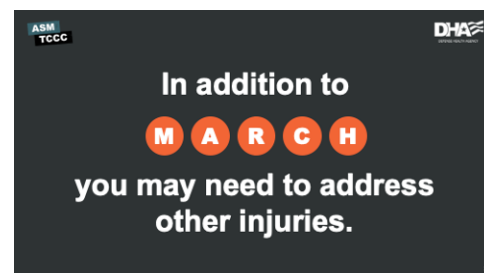
This is not hypothermia due to cold weather, but you can prevent it by:

- keep clothing/uniform on the casualty
 - replace extremely wet clothing if possible and keep the casualty dry
 - keep the casualty off the ground, by placing a barrier between the casualty and the ground...or lifting them off the ground, if possible
- NOTE:** Contact with the ground increases loss of body heat.
- use dry blankets, poncho liners, sleeping bags, or anything that will retain heat
 - minimize the casualty’s exposure to the environment

NOTES:

SLIDE 31: IN ADDITION TO MARCH

Beyond **MARCH**, there are additional injuries that you should identify and may need your attention.



SLIDE 32: SECONDARY INJURIES

After you have addressed the priorities using the **MARCH** protocol, identify and provide care as needed for the following injuries:

- eye trauma
- head injury
- burns
- fractures

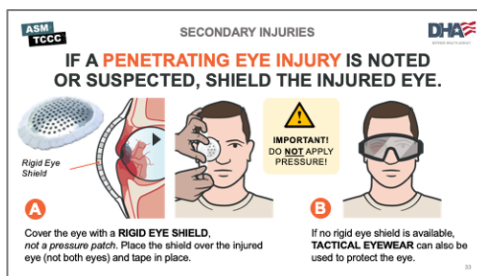


NOTES:

SLIDE 33: EYE TRAUMA

If a penetrating eye injury is seen or suspected, you must shield the injured eye. Cover the eye with a rigid eye shield, **not a pressure patch!**

Place a concave shield over the injured eye, not both eyes, and tape in place. If there is a protruding object in the eye, bandage in place—do NOT remove. Tactical eyewear can be used to protect the eye if a rigid eye shield is not available.

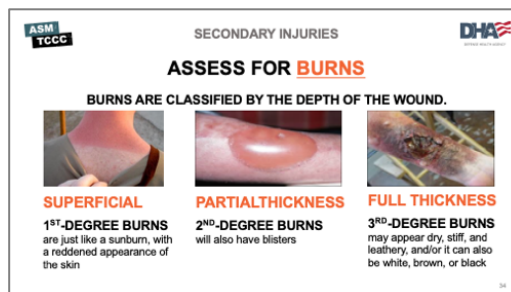


NOTES:

SLIDE 34: ASSESS FOR BURNS

Burns are classified according to their depth as first, second, and third-degree burns.

- First-degree burns are just like a sunburn, with a reddened appearance of the skin.
- Second-degree burns will also have blisters.



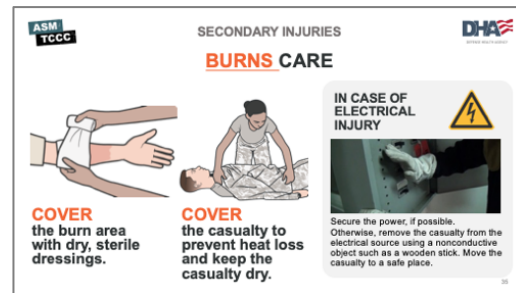
- Third-degree burns may appear dry, stiff, leathery and can be white, brown or black and will be less painful.

NOTES:

SLIDE 35: BURN CARE

Burn care in TCCC is very basic. Cover the burn area with dry, sterile dressings. Prevent hypothermia by removing and replacing wet clothing, move to a dry or insulated surface, and cover with anything that will retain heat and keep the casualty dry.

One potential cause of burns is electrical injury. In the case of an electrical injury, secure the power, if possible. Otherwise, remove the casualty from the electrical source using a non-conductive object. Move the casualty to a safe place and begin your rapid casualty assessment as previously discussed.



Pay close attention to their airway, breathing, and always assess for secondary injuries and shock.

NOTES:

SLIDE 36: ASSESS FOR FRACTURES

Fractures can be closed or open as seen here in the pictures. Open means that there is a break in the skin in conjunction with the fracture, often with protruding bone. Closed means that there is no external wound associated with the fracture.

The warning signs that an arm or leg might be fractured include:

- significant pain along with marked swelling
- an audible or perceived “snap”



- different length or shape of limb
- loss of pulse or sensation in the injured arm or leg
- crepitus (a crackling/popping sound under the skin when pressure is applied)

NOTES:

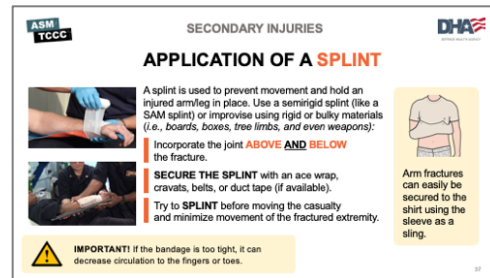
SLIDE 37: APPLICATION OF A SPLINT

If possible, you should splint all fractures. A splint is used to prevent movement while holding an injured arm/leg in place when a fracture is suspected.

If a semi-rigid splint (like a SAM Splint) is not available, create an improvised splint, using rigid or bulky materials such as boards, boxes, tree limbs and even weapons. Incorporate the joint above and below the fracture. Secure the splint with an ace wrap, cravat(s), belt(s), or duct tape, if available.

Try to splint before moving the casualty to minimize movement of the fracture. Arm fractures can be easily stabilized using a shirt as a sling.

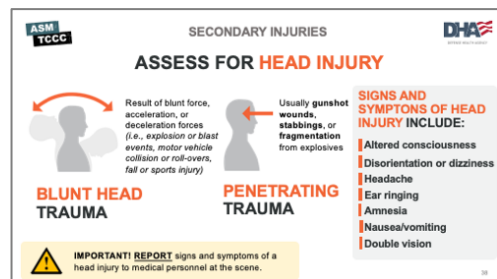
Make sure not to wrap the splint too tight. It may cut off circulation below the splint. If there is numbness, tingling or increased pain or if the finger/toes turn pale or bluish, loosen the bandage. Increased swelling may occur, so continue to monitor closely.



NOTES:

SLIDE 38: ASSESS FOR HEAD INJURY

It is critically important to report findings of a head injury to medical personnel at the scene, since a lack of rapid and appropriate medical care can worsen the head injury and the eventual outcome. Head trauma can be either blunt or penetrating.



Blunt head trauma is a result of blunt force, acceleration, or deceleration forces such as in an explosion or blast event, motor vehicle crashes or roll-overs, falls or sports injuries. Penetrating trauma is usually from gunshot wounds, stabbings or fragmentation from explosives. Signs and symptoms of a head injury include:

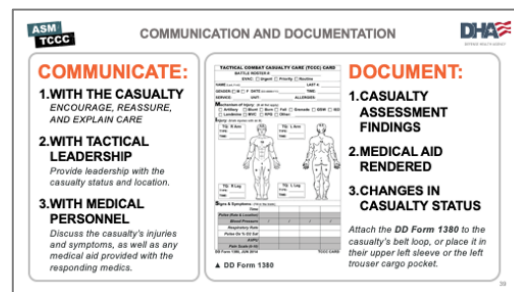
- altered consciousness
- disorientation or dizziness
- headache
- ringing in the ears
- nausea and/or vomiting
- amnesia (meaning they don't remember where they are or what happened)
- double vision

Head injuries must be reported and documented, so any information you can collect about the potential mechanisms of injury or observations after interacting with the casualty is very important.

NOTES:

SLIDE 39: COMMUNICATION AND DOCUMENTATION

Trainer Note: It is best to hand out copies of the DD Form 1380 and ask the students to review the reference material during their time at the course.



It is important to communicate at all levels, including with the casualty, with your leadership, and with on-scene medical personnel once they arrive.

Document as much of the following information as possible:

1. name, gender
2. time
3. how the injury occurred (e.g., explosion, vehicle accident, burn, fall, gunshot wound, etc.)
4. findings from the rapid casualty assessment, including all identified injuries
5. medical aid provided (e.g., tourniquets, hemostatic dressing, pressure bandage, burn dressing, hypothermia prevention, eye-shield, splints/slings, etc.) changes in the casualty's status or any other information deemed important

Make sure to secure this information on the casualty by attaching it to the casualty's belt loop or placing it in their upper left sleeve or the trouser cargo pocket. Forward the card with the casualty to the next level of care. This information is critical to the continuing

care of the casualty. If a DD Form 1380 or a TCCC Casualty Card is not available, you can also write directly on the casualty, such as on their forehead or body (T for tourniquet).

NOTES:

SLIDE 40: TEST ON KNOWLEDGE

Read the scenario slowly and question options. Pause to allow the students to determine the correct answer.

Answer: #3 Tourniquet to the right thigh is the correct choice.

TEST ON KNOWLEDGE

You have encountered an active shooter situation. An unconscious casualty has sustained multiple gunshot wounds.

Your assessment reveals the following: two open chest wounds from apparent gunshots, and bright red blood squirting from the lower right thigh. The casualty is in respiratory distress.

What is the most important priority in the care of this casualty?

1. Airway maneuvers
2. Wound packing of the right thigh
3. Tourniquet to the right thigh
4. Pressure dressing to the right thigh

NOTES:

SLIDE 41: IN SUMMARY

TCCC is the standard of care in prehospital battlefield medicine.

By following the **MARCH** sequence to perform a rapid casualty assessment and by using the lifesaving skills you will be taught in this course... **YOU CAN SAVE A LIFE!**

Using the **TCCC** standard of care in Prehospital Battlefield Medicine

...following the **MARCH** sequence to perform a RAPID CASUALTY ASSESSMENT

...and providing **LIFESAVING SKILLS**

...YOU can SAVE A LIFE!

NOTES:

SLIDE 42: CLOSING

Your job is to act! Provide lifesaving skills. Document the medical aid you provide so it can be passed along to ensure continuity of medical care. Assist with the evacuation to help get the casualty to the best medical care as soon as possible.

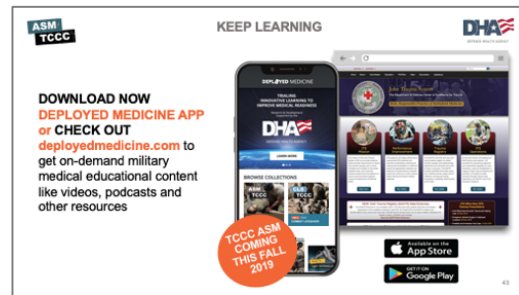


NOTES:

SLIDE 43: KEEP LEARNING

This information and all the instructional videos you see today are available on a free mobile app called Deployed Medicine or on www.deployedmedicine.com.

This resource is available in Apple and Android app stores and is the authoritative source for TCCC medical training for the DOD’s Joint Trauma System.



In addition to the All Service Member materials, there are plenty of other TCCC videos and resources. Download this app onto your personal mobile device to stay up to date, as TCCC practices can change, and you want to stay ready and keep learning!

NOTES: