SPEAKER NOTES

MODULE 09 – HEMORRHAGE CONTROL IN TFC

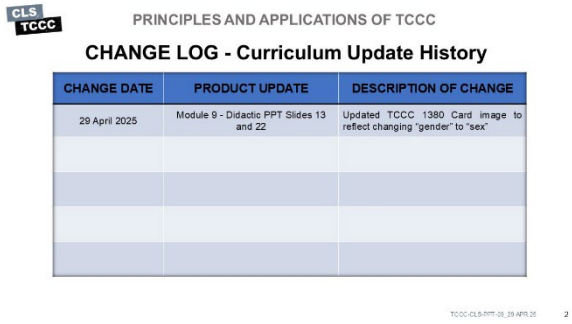
SLIDE 1 – TITLE SLIDE

Good morning/afternoon, my name is (insert here) and I will be your lead trainer for Module 9: Circulation/Hemorrhage control in the Tactical Field Care (TFC) environment.

Before we get started are there any questions?

SLIDE 2 – CHANGE LOG

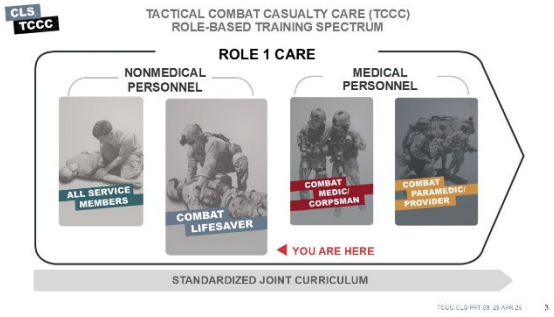
The Curriculum Change Log serves as a centralized reference to quickly track recent updates to training materials. It supports trainers by promoting clear communication, accountability, and alignment, helping stakeholders and learners understand what changes were made, why they were implemented, and when they occurred.



SLIDE 3 – 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 and 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.

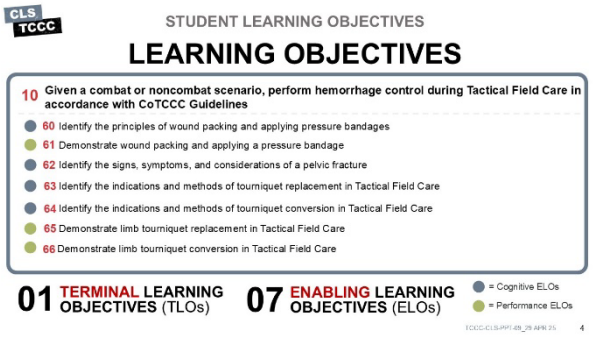
Your role as a CLS is to treat the most common causes of death on the battlefield, which are massive hemorrhage and airway/respiratory problems. Also, you are given the skills to prevent complications and treat other associated but not immediately life-threatening injuries.

SPEAKER NOTES

SLIDE 4 – TLO/ELO

The TCCC-CLS course is built on a foundation of learning objectives. These objectives lay out the basic structure of the course and describe the knowledge and skills you are expected to acquire by the end of the course.

The module has **one Terminal Learning Objective**, or TLO. The TLO is supported by a series of Enabling Learning Objectives, or ELOs. This graphic shows how the 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.



SLIDE 5 – THREE PHASES OF TCCC

TCCC is organized into Phases of Care that start at the point of injury. These phases are relevant to combat and noncombat trauma scenarios:

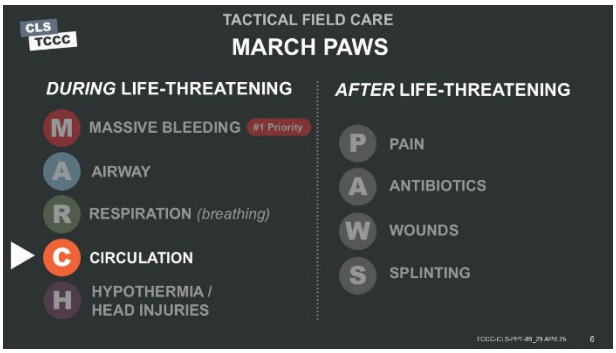
1. **Care Under Fire or Care Under Threat** is the aid rendered at the trauma scene while there is still an active threat. Available medical equipment is limited to that carried by an individual or found in a nearby first aid kit. Massive bleeding is the only medical priority that requires your attention during this phase, as you are actively dealing with an ongoing threat in a potentially chaotic and dangerous situation.
2. **Tactical Field Care** is the care provided once the threat has been neutralized and/or the scene is safe or the casualty has moved/been moved out of the immediate threat situation. 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 treated. Medical equipment is still limited. Time to arrival of medical personnel or evacuation may vary considerably, depending on the tactical situation, etc.
3. **Tactical Evacuation Care** is the care rendered during and once the casualty has been moved by an aircraft, vehicle, or other mode of transportation for evacuation to a higher level of care. Additional medical personnel and equipment are typically available in this phase of casualty care.

Remember: The goal of TCCC and the role of the CLS are to rapidly assess casualties to identify and treat potentially life-threatening injuries and keep the casualty alive long enough to reach a higher level of medical care.

SPEAKER NOTES

SLIDE 6 – MARCH PAWS

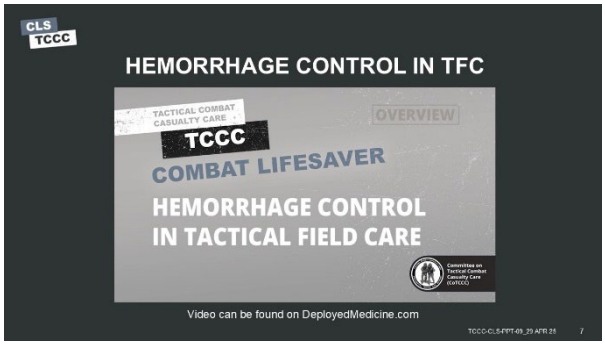
Hemorrhage control assessment and management in the Tactical Field Care phase falls under the **"C,"** for **C**irculation, in the MAR**C**H PAWS sequence.



SLIDE 7 – HEMORRHAGE CONTROL IN TFC (VIDEO)

Play video.

1. Unrecognized hemorrhage
2. Junctional areas
3. CoTCCC-recommended tourniquets
4. CoTCCC-recommended hemostatic dressings
5. Improvised junctional tourniquet
6. Pulse(s) checked
7. Reassessment
8. Pelvic fracture(s)
9. Findings reported

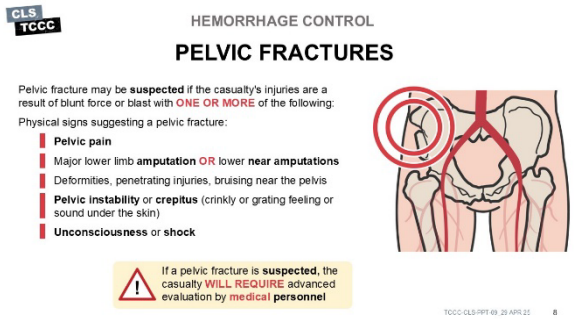


SLIDE 8 – PELVIC FRACTURES

In TFC, another key injury for which the casualty should be assessed is a ***pelvic fracture***.

Pelvic fractures can be a cause of massive internal bleeding and impact circulation, which is the **"C"** in the MARCH PAWS sequence.

A pelvic fracture may be suspected if the casualty's injuries are a result of blunt force or blast with **ONE OR MORE** of the following physical signs suggesting a pelvic fracture:



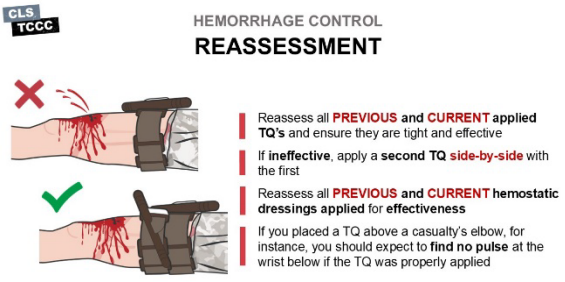
- Pelvic pain
- Major lower-limb amputation OR lower-limb near amputations
- Pelvic deformities, penetrating injuries, or bruising near the pelvis
- Pelvic instability or crepitus, which is a crinkly or grating feeling or sound under the skin
- Unconsciousness or shock

If a pelvic fracture is suspected, the casualty **WILL REQUIRE** advanced evaluation by medical personnel, and you should notify medical personnel of the potential for a pelvic fracture as soon as possible.

SLIDE 9 – REASSESSMENT

Hemorrhage control in the TFC phase takes place after massive bleeding control that occurs in the Care Under Fire phase.

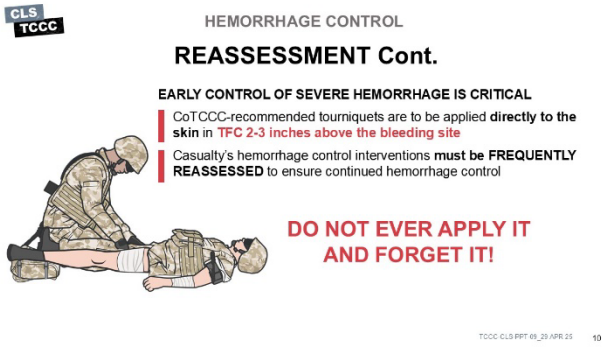
It is possible that it **did not occur**, and this may be the first opportunity to address massive bleeding as well, so there is significant urgency.



The first step is to reassess ALL PRIOR hemorrhage control interventions for effectiveness.

Check all TQs and hemostatic dressings that were applied and ensure they are tight and effective.

SLIDE 10 – STRATEGIES AND LIMITATIONS



Early control of severe hemorrhage is critical.

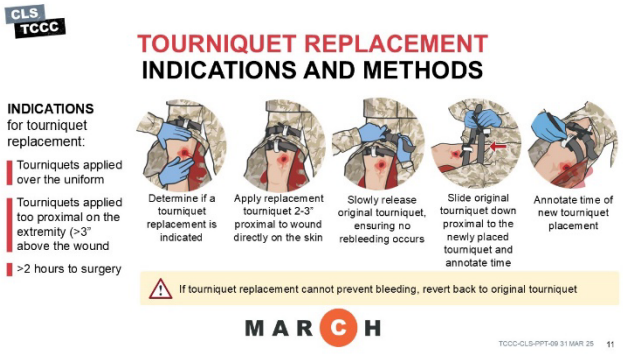
In the TFC phase, CoTCCC-recommended TQs should be applied directly to the skin **2–3 inches above the bleeding site**. This is *different* from the high & tight placement over clothing that may have occurred in the CUF phase.

Always remember that the casualty's hemorrhage control interventions must be **FREQUENTLY REASSESSED** to ensure continued hemorrhage control. This includes reassessments at frequent time intervals and any time the casualty is moved or the casualty's status changes. Watch the casualty for signs of shock.

Your actions will help ensure bleeding control.

DO NOT EVER APPLY IT AND FORGET IT!

SLIDE 11 – WOUND PACKING and PRESSURE DRESSING



The proper technique for applying a hemostatic dressing with a pressure bandage is to first **identify the exact source of bleeding** and pack the wound.

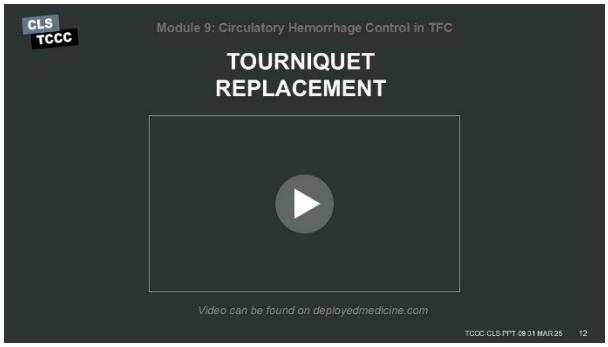
You should pack the wound with the hemostatic dressing while maintaining CONSTANT direct pressure at the source of bleeding.

After the wound is packed, you must hold direct pressure to the packing over the wound for **3 minutes**. **Do not** check for bleeding control during these 3 minutes.

After 3 minutes, if bleeding is controlled, you should secure the wound packing with a pressure bandage. If the bandage has a pressure bar, pull the bandage TIGHT, and reverse it back over the top of the pressure bar, forcing it down onto the pad. If there is no pressure bar, make sure to keep tension while wrapping the elastic bandage, which is best done with short pulls and tugs of the bandage as you wrap it around the wound.

SPEAKER NOTES

SLIDE 12 – WOUND PACKING



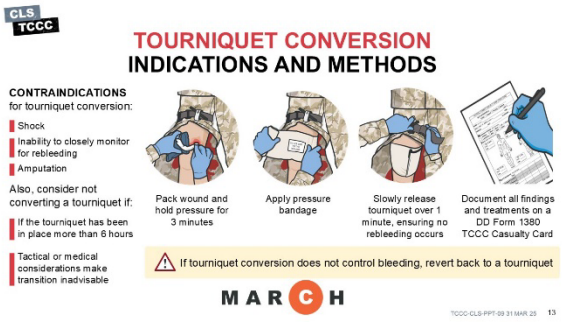
While packing a wound, maintain constant, direct pressure at the source of bleeding.

Once the dressing is applied, hold direct pressure on the gauze over the wound for at least 3 minutes. Then, carefully observe for blood continuing to flow from under the gauze to determine if bleeding has been controlled. Once you are sure the bleeding has stopped, apply a pressure bandage over the hemostatic dressing.

If you placed a tourniquet above a casualty's elbow, for instance, you should expect to find no pulse at the wrist below that elbow if the tourniquet was properly applied, and there should be no continued bleeding from the wound.

Make sure there is no continued bleeding from any prior hemostatic dressings that were placed.

SLIDE 13 – PRESSURE BANDAGE REASSESSMENT



It is also necessary to reassess any previously applied pressure bandages.

First, make sure there is no continued bleeding from the wound.

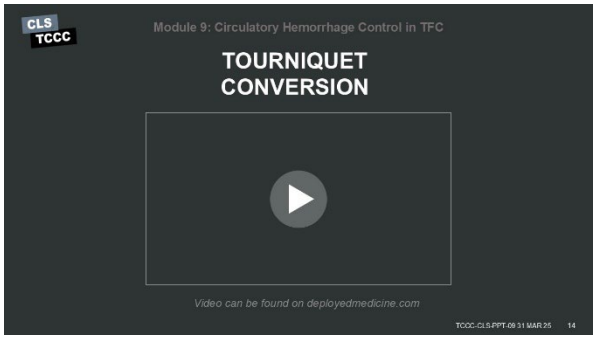
Then, check for circulation **BELOW** the pressure bandage by feeling for the distal pulse (a pulse below the bandage).

If the skin **BELOW** the pressure bandage becomes cool to the touch, bluish, or numb, or if the pulse below the pressure dressing is no longer present, the pressure bandage may be too tight.

If circulation is **BLOCKED** or STOPPED, loosen and retie the bandage.

Dressings and bandages should be reassessed and checked routinely and EVERY TIME a casualty is moved.

SLIDE 14 – IF PRESSURE BANDAGE IS INEFFECTIVE



You must make sure the pressure bandage is still effective and bleeding is still controlled.

If the pressure bandage or hemostatic dressing is ineffective, APPLY A TOURNIQUET **2–3 inches above the bleeding site**, if possible.

If unable to place a tourniquet and the pressure bandage is ineffective AND/OR blood soaked, REPLACE the pressure dressing with a new hemostatic dressing.

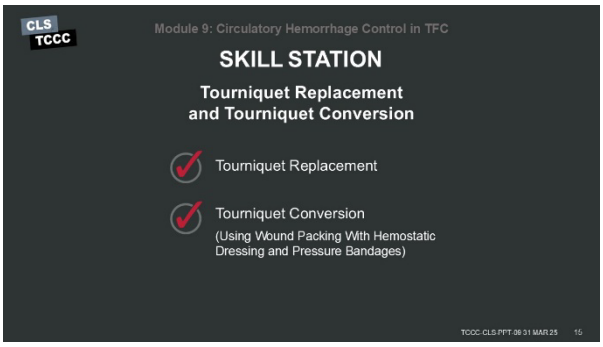
Pack the wound with the hemostatic dressing, maintaining CONSTANT direct pressure at the source of bleeding within 90 SECONDS, to be effective.

SPEAKER NOTES

SLIDE 15 – PRESSURE BANDAGE (VIDEO)

Play video

1. Properly apply pressure dressing
2. Use the sterile side on top of hemostatic dressing
3. Wrap properly and secure
4. Assess circulation
5. Document treatment



SLIDE 16 – SKILL STATION

At this time, we will break into skill stations to practice the following skills:

- Wound Packing with Hemostatic Dressing and Pressure Bandage

SLIDE 17 – SUMMARY

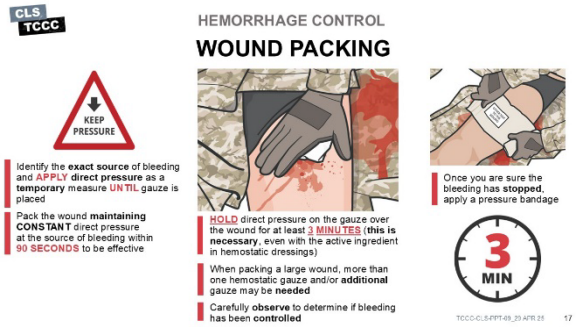
You should now understand the need to reassess all hemorrhage control interventions that may have been applied previously.

You should also understand the need to replace or reapply any ineffective hemorrhage control intervention.

All of these interventions are designed to eliminate further bleeding and prevent the casualty from going into shock or worsening shock.

You should frequently reassess for shock by checking for a radial pulse and other signs of inadequate hemorrhage control.

Of course, if not already done, clearly mark ALL tourniquets with the time of tourniquet application and document all findings and treatment on the DD Form 1380 TCCC Casualty Card.

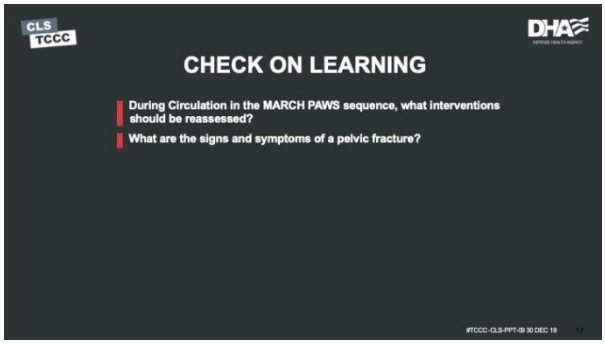


SLIDE 18 – CHECK ON LEARNING

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

Now for a check on learning.

1. During Circulation in the MARCH PAWS sequence, what interventions should be reassessed?
   - Previously applied tourniquets and hemostatic dressings
2. What are the signs and symptoms of a pelvic fracture?



- Severe blunt force or blast injury with one or more of the following:
  - Pelvic pain
  - Major lower-limb amputation OR lower near amputations
  - Deformities, penetrating injuries, bruising near the pelvis
  - Pelvic instability or crepitus (crinkly, or grating feeling or sound under the skin)
  - Unconsciousness or shock

SLIDE 19 – QUESTIONS