

## JOINT TRAUMA SYSTEM CLINICAL PRACTICE GUIDELINE (JTS CPG)



### Documentation in Prolonged Field Care (CPG ID:72)

This CPG is meant to provide medical professionals who treat severely injured or sick patients in austere environments with recommendations for documentation that will allow them and subsequent providers along the evacuation chain to optimally manage complex, often unstable casualties.

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## INTRODUCTION

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This Role 1, prolonged field care (PFC) Clinical Practice Guideline (CPG) is intended to be used after Tactical Combat Casualty Care (TCCC) guidelines when evacuation to higher level of care is not immediately possible. A provider of PFC must first and foremost be an expert in TCCC. This CPG is meant to provide medical professionals who treat severely injured or sick patients in austere environments with recommendations for documentation that will allow them and subsequent providers along the evacuation chain to optimally manage complex, often unstable casualties. Recommendations follow a “minimum,” “better,” “best” format that provides alternate methods when optimal hospital options are unavailable.

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## BACKGROUND

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PFC frequently involves the care of complicated, critically injured or sick casualties who are normally managed in medical treatment facilities. For patients that survive the initial trauma or sickness, the biggest risk of death is from circulatory shock and its complications. All severely injured and sick patients must be closely monitored for signs of shock and decompensation because the best treatment for shock is early recognition, treatment of the cause, and resuscitation. One method used by intensive care units to monitor critical patients is trending vital signs, physical exams, and fluid outputs recorded on a flowsheet that facilitates recognition of changes that could mark the early signs of decompensation.

In the PFC environment, one of the few techniques available to the medical provider that is identical to those used in hospitals is documentation of key clinical trends. It is critical that Medics are trained on the interpretation of clinical trends. It is also essential that Medics cross-train nonmedical teammates to take and record vital signs, outputs, key exam findings, and interventions to free the medic to do other tasks as well as to sleep if care of the casualty is especially prolonged.

Documentation that can help the medic and successive caregivers manage complicated patients includes:

- TCCC Card, DD1380
- PFC flowsheet
- Telemedicine guide
- Handoff report

Finally, completion of the PFC after-action report (AAR) will contribute greatly to performance improvement to develop training, tools, and techniques for improving the care of casualties in austere environments.

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## PATIENT DEMOGRAPHICS

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While some casualties will be unable to provide name, identification number, date of birth (DOB), or other identifying information, every effort should be made to collect and document this information in order to facilitate the inclusion of prehospital documentation into the patient’s medical record. This information not only helps the longitudinal care of casualties as they progress through the evacuation chain, it also provides the vital link to connect prehospital treatments delivered to survival and long-term outcomes in order to guide recommendations for improving trauma care.

**NOTE:** Medical treatment facilities use pseudo names assigned when a patient's real name is unknown. In such cases, every effort should be made to continue the same pseudo name through transfers of care. Prehospital documentation submitted after patient transfer, to include AARs, should use the same name or pseudo name assigned at the first treating MTF.

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## DOCUMENTATION OF PREHOSPITAL CARE

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### GOALS

- Transmit important medical information to the next level of care
- Permanently record information vital to service members injured in combat
- Contribute to performance improvement in prehospital care.

### Minimum: TCCC Card DD1380

- The DD1380 is organized as a MIST (Mechanism, Injuries, Signs and Symptoms, Treatments) report ([Appendix A](#)).
- Note the time casualty is received and include time of injury (if known and different from when received) and time of all key interventions (e.g., tourniquet, blood transfusion, tranexamic acid [TXA] dosing).
- List injuries and annotate on the diagram. Tourniquets and tourniquet times are also annotated on the diagram.
- Vital signs, including mental status AVPU (alert or responsive to voice, pain, or unresponsive) and pain scale, should be recorded to the greatest extent possible—up to four sets of vital signs can be recorded on the TCCC card.
- Document treatments to include external hemorrhage control, airway, breathing, fluids, medications, and other interventions on the reverse side of the TCCC card.

### Better: PFC Flowsheet

As a follow-on to the TCCC card, the PFC flowsheet is used to document trends over time and is the most useful tool to recognize important clinical changes in complex casualties such as decompensation, response to resuscitation, development of complications, effectiveness of medications, etc. The PFC flowsheet is one of the most effective ways to improve the level of care provided in PFC situations.

- When prehospital care transitions to PFC, documentation should transition from the TCCC card to the PFC flowsheet. There is no exact time for this transition to occur; however, once all of the available time blocks on the TCCC card are filled and evacuation to higher level of care is not imminent, then documentation can transition to the PFC flowsheet ([Appendix B](#)).
- The PFC flowsheet not only serves to document care and identify trends but also contains a checklist of interventions that may be needed through the included patient care and nursing care checklists. Such checklists can greatly aid task-saturated, fatigued Medics by providing a quick point of reference for important tasks that should be performed regularly to improve care and reduce the risk of complications to their patients.

- The PFC flowsheet also includes:
  - Vital signs
  - Fluid input and output
  - Medication times, route, dose
  - Physical exam findings
  - Problem list
  - Treatment plan
  - Telemedicine call script

**Best: AAR**

- An AAR should be completed after patient handoff. In addition to the TCCC card and PFC flowsheet, a structured AAR is used to collect lessons learned and improve care. In cases where documentation is not able to be completed before patient handoff or was lost after handoff, the AAR can also serve as a supplement to the medical record.
- TCCC and PFC AARs are available at [https://jts.health.mil/index.cfm/PI\\_CPGs/cpgs](https://jts.health.mil/index.cfm/PI_CPGs/cpgs)
- TCCC or PFC AARs, along with any medical documentation not completed before patient handoff, should be completed within 24 hours of patient handoff and submitted to the Joint Trauma System (JTS) prehospital organizational email box: [usarmy.jbsa.medcom-aisr.list.jts-prehospital@mail.mil](mailto:usarmy.jbsa.medcom-aisr.list.jts-prehospital@mail.mil)
- The unclassified medical AAR should be accomplished in addition to unit-required classified AARs.

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**TELEMEDICINE GUIDE**

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**GOAL**

Goal: Facilitate communication between prehospital provider and telemedicine consultant.

Rehearsal of telemedicine consultation between prehospital providers and remote physician consultants has shown that communication is optimized when the caller completes a telemedicine guide or script before calling the consultant and uses it during the consultation. In addition to transmitting medical information to the consultant, it is important for the caller to provide information about the care context and a summary of capabilities currently available. An image of the casualty and an image of the care environment are helpful for remote consultants to understand the operational constraints faced by the local caregiver. Capabilities that are important to convey to remote consultants may include the training level of the provider, available medications, medical supplies, monitoring, ultrasound, etc. Reading or sending a photograph of a written capabilities list will more quickly orient the consultant to the operational environment of the caller and reduce time spent asking the caller for items that are not available. If urgent teleconsultation is needed, do not delay calling to fill out a guide sheet or send e-mails. For additional details, see Teleconsultation in prolonged field care position paper.<sup>1</sup>

**Minimum:** Read from TCCC card.

**Better:** Use telemedicine report incorporated in the PFC flowsheet.

**Best:** Use the Virtual Critical Care Consultation guide (Appendix C) and send a picture of casualty, capabilities, and vital sign trends to the consultant via email or text using appropriate operational security and protections of patient privacy.

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## HANDOFF REPORT

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### GOAL

Goal: Ensure safe transition to the next level of care.

Adverse events may occur due to poor handover of a patient from one level of care to another. The PFC provider's job is not done until the receiving team understands the patient's condition and can begin to manage the patient appropriately.

Summarize in organized format:

1. Overall condition of the patient: stable or unstable; better, same, or worse.
2. Mechanism of injury or illness
3. Injury(ies), current physical exam
4. Vital signs to include trends and urine output
5. Treatments (procedures, dressings, airway management, fluids, blood products, medications)

**Minimum:** Written handoff report that follows the MIST format (e.g., TCCC Card).

**Better:** Add the PFC flowsheet.

**Best:** Add a dedicated handoff sheet (e.g., SBAR handoff report<sup>2</sup>, PFC handoff report<sup>3</sup>).

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## ELECTRONIC DOCUMENTATION

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Electronic documentation is the standard in hospitals and advanced field medical facilities. Devices such as the Tempus Pro (Remote Diagnostic Technologies LTD, United Kingdom) and BATDOK (USAF, 711 Human Performance Wing, OH) are devices designed for the operational environment that can compile detailed patient records that support many of the recommendations in this CPG. These and other similar devices and applications may improve the accuracy of patient records, reduce the burden of data entry for the prehospital provider, and provide other features to improve patient care such as critical value alarms and telemedicine communication. Where such devices are fielded and supported with network connectivity, their use for austere PFC environments is encouraged.

JTS hosts a variety of fillable forms at [https://jts.health.mil/index.cfm/documents/forms\\_after\\_action](https://jts.health.mil/index.cfm/documents/forms_after_action)

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**REFERENCES**

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1. Vasios W, Pamplin JC, Powell D, et al. Teleconsultation in prolonged field care. *J Spec Oper Med.* 2017;17(3);141–144.
2. Air Force Instruction 48-307, Volume 1, En Route Care and Aeromedical evacuation Medical Operations, 9 Jan 2017.
3. Prolonged Care MTF Handover Sheet. <https://prolongedfieldcare.org> Accessed 28 Dec 2017.

**APPENDIX A: TACTICAL COMBAT CASUALTY CARE CARD, DD 1380**

**TACTICAL COMBAT CASUALTY CARE (TCCC) CARD**

BATTLE ROSTER #: \_\_\_\_\_  
 EVAC:  Urgent  Priority  Routine

NAME (Last, First): \_\_\_\_\_ LAST 4: \_\_\_\_\_  
 GENDER:  M  F DATE (DD-MMM-YY): \_\_\_\_\_ TIME: \_\_\_\_\_  
 SERVICE: \_\_\_\_\_ UNIT: \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

**Mechanism of Injury:** (X all that apply)  
 Artillery  Blunt  Burn  Fall  Grenade  GSW  IED  
 Landmine  MVC  RPG  Other: \_\_\_\_\_

**Injury:** (Mark injuries with an X)

**TQ: R Arm**  
 TYPE: \_\_\_\_\_  
 TIME: \_\_\_\_\_

**TQ: L Arm**  
 TYPE: \_\_\_\_\_  
 TIME: \_\_\_\_\_

**TQ: R Leg**  
 TYPE: \_\_\_\_\_  
 TIME: \_\_\_\_\_

**TQ: L Leg**  
 TYPE: \_\_\_\_\_  
 TIME: \_\_\_\_\_

**Signs & Symptoms:** (Fill in the blank)

Time				
<i>Pulse (Rate &amp; Location)</i>				
<i>Blood Pressure</i>	/	/	/	/
<i>Respiratory Rate</i>				
<i>Pulse Ox % O2 Sat</i>				
<i>AVPU</i>	▼	▼	▼	▼
<i>Pain Scale (0-10)</i>	▼	▼	▼	▼

DD Form 1380, JUN 2014 TCCC CARD

BATTLE ROSTER #: \_\_\_\_\_  
 EVAC:  Urgent  Priority  Routine

**Treatments:** (X all that apply, and fill in the blank) *Type*

**C:** TQ-  Extremity  Junctional  Truncal  
 Dressing-  Hemostatic  Pressure  Other \_\_\_\_\_

**A:**  Intact  NPA  CRIC  ET-Tube  SGA \_\_\_\_\_

**B:**  O2  Needle-D  Chest-Tube  Chest-Seal \_\_\_\_\_

**C:**

	Name	Volume	Route	Time
<b>Fluid</b>			▼	
			▼	
<b>Blood Product</b>			▼	
			▼	

**MEDS:**

	Name	Dose	Route	Time
<b>Analgesic</b> (e.g., Ketamine, Fentanyl, Morphine)			▼	
			▼	
<b>Antibiotic</b> (e.g., Moxifloxacin, Ertapenem)			▼	
			▼	
<b>Other</b> (e.g., TXA)			▼	
			▼	

**OTHER:**  Combat-Pill-Pack  Eye-Shield ( R  L)  Splint  
 Hypothermia-Prevention Type: \_\_\_\_\_

**NOTES:**

FIRST RESPONDER  
 NAME (Last, First): \_\_\_\_\_ LAST 4: \_\_\_\_\_

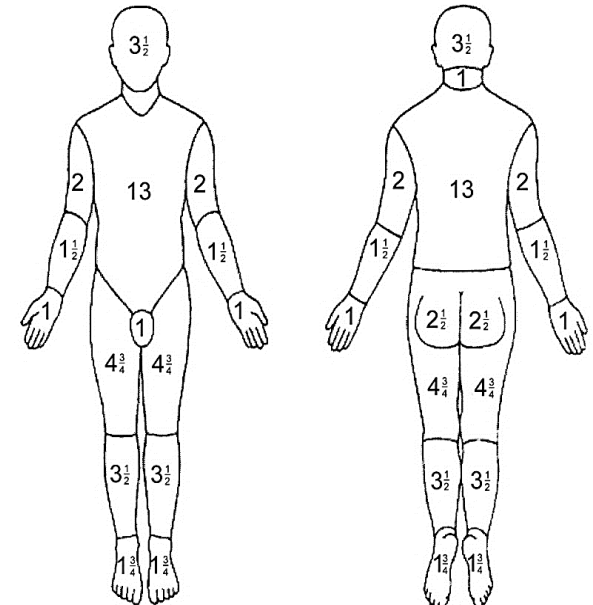
DD Form 1380, JUN 2014 (Back) TCCC CARD

APPENDIX B: PROLONGED FIELD CARE FLOWSHEET –PAGE 1 (Newest Version Available at Prolongedfieldcare.org)

Day																		D	Checklist	
Hour																		H	Reassess Tx	
Minute																		M	Expose	
BP	200																		200	Detailed Exam
	190																		190	Send MIST Report
	180																		180	Monitors
	170																		170	2nd IV/IO
	160																		160	GCS/Neuro/MACE
	150																		150	Analgesia
	140																		140	Sedation
	130																		130	NG / OG
	120																		120	Upgrade Airway
	110																		110	Post Cric Checklist
	100																		100	Vent w/ PEEP
	95																		95	Hypothermia Tx
	90																		90	Recalc TBSA & Fluids
	85																		85	Ultrasound eFast
	80																		80	Fluid Challenge
	75																		75	1st TXA dose (<3hrs)
	70																		70	Blood Type Card
65																		65	FWB Transfusion	
60																		60	Convert TQ <4hrs	
55																		55	Foley/Bladder Tap	
50																		50	Adjust Vent Settings	
45																		45	UA Dipstick	
40																		40	Clear C-Spine	
35																		35	Position Pad Patient	
30																		30	Peripheral Pulses	
25																		25	Compartment Syndrome	
20																		20	Escharotomy	
15																		15	Reduce / Splint Fx	
10																		10	DVT Prophylaxis	
5																		5	Antibiotic War	
0																		0	Wound Tx	
No read																		No read	Tetanus	
Output																			Teleconsult	
Fluid Input																			Labs	
Pain scale/RASS																			X-Ray / Imaging	
AVPU/Neuro/MACE																			PreOp Eval	
Eye response	4																		Debridement	
Oral Response	5																		Nursing Care Reminders	
Motor Response	6																		Vitals q1h	
GCS Total	15																		Flush Saline Locks	
Drug/Intervention:	Dose:																		Suction ET Tube	
																			Reposition q2hrs (30° Each side)	
																			Change Blood Tube q4hrs	
																			Oral Care / Hygiene q4hrs	
																			Foley Care q4hrs	
																			Sponge Bath q8hrs	
																			Change IV Bag q24hrs	
																			Change Foley Cath q72hrs	
																			Change IV Lines q72hrs	
																			Change HME q72hrs	



PROLONGED FIELD CARE FLOWSHEET PAGE 2

Name:		Date:	Time:	Blood type:	EVAC Category:
S:				MOI	
A:				Injuries / illness / problems	Treatment plan
M:				1	
P:				2	
L:				3	
E:				4	
TQ 1 time on:		TQ 2 time on:	TQ 3 time on:	TQ 4 time on:	TXA Dose 1 on:
TQ 1 Converted:		TQ 2 Converted:	TQ 3 Converted:	TQ 4 Converted:	TXA Dose 2 on:
Notes:				Telemedicine Call Script	
				This is _____, an _____ (Job Position) I have a patient with _____ who I think has _____ and I need _____ Chief	
				Complaint _____ Brief _____ History _____ Vitals HR _____ RR _____ BP _____ Temp _____ Pulse Ox _____ UOP _____ AVPU _____ Exam Findings _____ _____	
				Recommendations _____ _____	
				Fluids/Meds _____ Interventions _____ Red Flags _____	

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**APPENDIX C: VIRTUAL CRITICAL CARE CONSULTATION GUIDE**


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1. Before calling, E-mail image of the casualty (wounds, environment, etc.), "capabilities" (back of page), & vital signs trends to \_\_\_\_\_
2. If call not answered: a) call next number on PACE or call back in 5 – 10 min.
3. If unable to provide information due to operational security, state so.

P:  
A:  
C:  
E:

This is \_\_\_\_\_ I am a (job/ position) \_\_\_\_\_  
**My best** contact info is: \_\_\_\_\_  
**YOUR best** contact info is (Consultant's number): \_\_\_\_\_ Alternate e-mail: \_\_\_\_\_

**\*\*\* PAUSE POINT to CONFIRM CONTACT INFO\*\*\***

I have a \_\_\_\_ year-old \_\_\_\_ (sex) \_\_\_\_\_ (active duty/foreign national/OGA,etc.), who has the following:

**Mechanism of Injury or known diagnosis(es)** \_\_\_\_\_ that occurred in (location) \_\_\_\_\_

The injury/start of care occurred \_\_\_\_\_ hours ago. Anticipated evacuation time is (range) \_\_\_\_\_

Injuries/Problems/Symptoms:

Treatments:

He/she is currently (circle) stable/ unstable, getting better/ getting worse/ getting worse rapidly

Known Medication Allergies/Past medical/Surgical history is:

I need help with (be specific if possible, i.e. "I need help reading this ECG," or "I need help stabilizing this patient," etc.)

Other Consultants have recommended:

**\*\*\* PAUSE POINT for Remote Consultant to ask clarification questions \*\*\***

**VITALS** (current & trend as of \_\_\_\_\_): HR \_\_\_\_\_ BP \_\_\_\_\_ RR \_\_\_\_\_ SpO2 \_\_\_\_\_ EtCO<sub>2</sub> \_\_\_\_\_ Temp.....

UOP(ml/hr) \_\_\_\_\_ over \_\_\_\_\_ (# hours) Mental Status (GCS/ AVPU)

**EXAM:** Neuro \_\_\_\_\_ Ext/ MSK \_\_\_\_\_

Heart \_\_\_\_\_ Pulses \_\_\_\_\_

Lungs \_\_\_\_\_ Skin/ Wounds \_\_\_\_\_

Abd \_\_\_\_\_

**LABS:** ABG: \_\_\_\_\_ Lactate: \_\_\_\_\_ Other: \_\_\_\_\_

**\*\*\* PAUSE POINT for Remote Consultant to ask clarification questions \*\***

**VIRTUAL CRITICAL CARE CONSULTATION GUIDE PAGE 2**

Plans/Recommendations		
PRIORITY	SYSTEM/PROBLEM	RECOMMENDATION
	Neuro or problem #1	
	CV or problem #2	
	Pulm or problem #3	
	GI or problem #4	
	Renal or problem #5	
	Endocrine or problem #6	
	MSK/ Wound or problem #7	
	Tubes, lines, drains or problem #8	
	Prophylaxis/prevention or prob#9	
	Other	
TO-DO/ FOLLOW-UP/TO-STOP	NOTES	
1.		
2.		
3.		
4.		
5.		
6.		

**\*\*\* PAUSE POINT, for Medic/Local Caregiver to ask clarification questions/READBACK\*\*\***

**Available "kit" (supplies, equipment, medications) !! IF POSSIBLE PHOTOGRAPH AND SEND VIA EMAIL BEFORE CALLING !!**

IV access:	IV	Central line	IO (location)	Other: _____
Monitor:	Propaq	Tempus	Foley	Graduated urinal    PulseOx only    Exam Only
	Other: _____			
Commo:	Tempus i2i ID: _____ THIAB: _____ SAT# _____ Local Cell# _____			
	Web VTC Address _____			
	Other (e.g. "FaceTime, VSee, Skype, etc.): _____			
IV Fluids:	Plasma-Lyte	LR	Normal Saline	3% saline    Other: _____
Colloids:	Hetastarch	Albumin	Other: _____	
Blood products:	Whole blood	PRBC	Plasma	FDP    Platelets    Other: _____
Medications:	Antibiotics: name/route/dose _____			
	Morphine IV/ PO	Other opioid (name/ IV/ PO): _____		
	Fentanyl IV/ PO (pop)	Ketamine		
	Midazolam	Diazepam (IV/ PO)		
	TXA	Other(s): _____		
Airway supplies:	ETT	Cric kit	LMA	Ventilator    BVM    O2    Suction
Misc:				

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**APPENDIX D: ADDITIONAL INFORMATION REGARDING OFF-LABEL USES IN CPGS**

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**PURPOSE**

The purpose of this Appendix is to ensure an understanding of DoD policy and practice regarding inclusion in CPGs of “off-label” uses of U.S. Food and Drug Administration (FDA)–approved products. This applies to off-label uses with patients who are armed forces members.

**BACKGROUND**

Unapproved (i.e. “off-label”) uses of FDA-approved products are extremely common in American medicine and are usually not subject to any special regulations. However, under Federal law, in some circumstances, unapproved uses of approved drugs are subject to FDA regulations governing “investigational new drugs.” These circumstances include such uses as part of clinical trials, and in the military context, command required, unapproved uses. Some command requested unapproved uses may also be subject to special regulations.

**ADDITIONAL INFORMATION REGARDING OFF-LABEL USES IN CPGS**

The inclusion in CPGs of off-label uses is not a clinical trial, nor is it a command request or requirement. Further, it does not imply that the Military Health System requires that use by DoD health care practitioners or considers it to be the “standard of care.” Rather, the inclusion in CPGs of off-label uses is to inform the clinical judgment of the responsible health care practitioner by providing information regarding potential risks and benefits of treatment alternatives. The decision is for the clinical judgment of the responsible health care practitioner within the practitioner-patient relationship.

**ADDITIONAL PROCEDURES****Balanced Discussion**

Consistent with this purpose, CPG discussions of off-label uses specifically state that they are uses not approved by the FDA. Further, such discussions are balanced in the presentation of appropriate clinical study data, including any such data that suggest caution in the use of the product and specifically including any FDA-issued warnings.

**Quality Assurance Monitoring**

With respect to such off-label uses, DoD procedure is to maintain a regular system of quality assurance monitoring of outcomes and known potential adverse events. For this reason, the importance of accurate clinical records is underscored.

**Information to Patients**

Good clinical practice includes the provision of appropriate information to patients. Each CPG discussing an unusual off-label use will address the issue of information to patients. When practicable, consideration will be given to including in an appendix an appropriate information sheet for distribution to patients, whether before or after use of the product. Information to patients should address in plain language: a) that the use is not approved by the FDA; b) the reasons why a DoD health care practitioner would decide to use the product for this purpose; and c) the potential risks associated with such use.