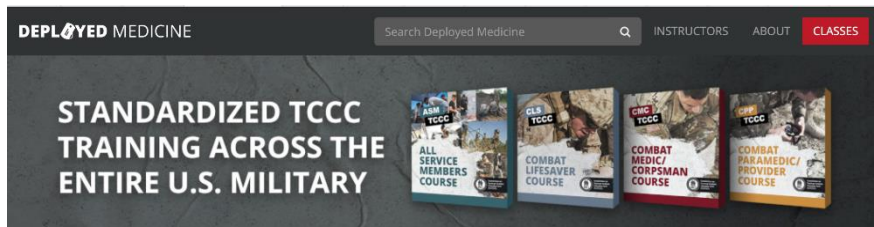


# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## MODULE 01: PRINCIPLES AND APPLICATIONS OF TACTICAL FIELD MEDICAL AID (TFMA)

- This course is based heavily on the United States Defense Health Agency, Joint Trauma System, Tactical Combat Casualty Care (TCCC), Combat Lifesavers Course.
- Adjustments have been made to comply with United Nations Policy.



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## Changes between TCCC and UN FMAC

- The UN equivalent to **Tactical Combat Casualty Care (TCCC)** = Tactical Field Medical Aid (TFMA)
- The UN equivalent to **TCCC Combat Lifesaver** = Field Medical Assistant (FMA)
- The UN equivalent to the **TCCC 9-Liner Medical Evacuation** = UN Evacuation 4 Liner
- The UN equivalent to **TCCC DD Form 1380** = UN Casualty Card
- The UN equivalent to **TCCC CASEVAC (MEDEVAC & TACEVAC)** = UN CASEVAC
- The UN equivalent to **TCCC Joint First Aid Kit (JFAK)** = Buddy First Aid Kit (BFAK)
- The UN equivalent to **TCCC Combat Lifesaver Bag (CLS Bag)** = UN Trauma Pack (UNTP)
- The UN equivalent to **TCCC Combat / Combatant** = Peacekeeping / Peacekeeper
- The UN equivalent to **TCCC Combat Wound Medication Pack (CWMP)** = Wound Medication Pack (WMP)

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

# PRINCIPLES AND APPLICATIONS OF TACTICAL FIELD MEDICAL AID (TFMA)

## TERMINAL LEARNING OBJECTIVES

**TO1** Given a combat peacekeeping or non-combat peacekeeping scenario, perform Tactical Field Medical Aid (TFMA)

**EO1** Demonstrate the application of TFMA skills in a combat peacekeeping or non-combat peacekeeping scenario (Comprehensive Module Practical Exercise)

**TO2** Describe the practice of TFMA

**EO2** Identify the leading causes of preventable death due to traumatic injuries, and the corresponding interventions to help increase chances of survival

**EO3** Describe the TFMA Phases of Care, and how intervention priorities differ in each phase

**EO4** Describe the application of TFMA in combat peacekeeping or non-combat peacekeeping settings across different environments

**EO5** Describe the role and responsibilities of a nonmedical UN member in rendering TFMA care

**EO6** Identify the key factors influencing TFMA

**EO7** Identify the importance of TFMA training

**EO8** Identify three objectives (or goals) of TFMA

## UN MANDATE FOR STANDARDIZED TRAINING

- Standardizes Field Medical Aid for all members
- Covers the use of standardized trauma training platforms

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## TCCC ONLINE RESOURCES

TCCC training and education resource is available at: [www.deployedmedicine.com](http://www.deployedmedicine.com)

It contains:

- Videos, podcasts, and resources
- Downloadable Clinical Practice Guidelines (CPGs)

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## COURSE CONTENTS

# WHAT THIS COURSE CONTAINS

- ☐ Principles and Applications of TFMA
- ☐ Medical Equipment
- ☐ Care Under Fire
- ☐ Principles and Application of Tactical Field Care
- ☐ Tactical Trauma Assessment
- ☐ Massive Hemorrhage Control
- ☐ Airway Management
- ☐ Respiration Assessment and Management
- ☐ Circulation/Hemorrhage Control
- ☐ Shock Recognition
- ☐ Hypothermia Prevention
- ☐ Head Injuries
- ☐ Eye Injuries
- ☐ Analgesics and Antibiotics
- ☐ Wound Management
- ☐ Burn Treatment
- ☐ Fractures
- ☐ Casualty Monitoring
- ☐ Pre-evacuation Procedures

## PRINCIPLES AND APPLICATIONS OF TFMA

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Video can be found at: [www.deployedmedicine.com](http://www.deployedmedicine.com)



## PRINCIPLES AND APPLICATIONS OF TFMA

# ROLES AND RESPONSIBILITIES OF THE FIELD MEDICAL ASSISTANT (FMA)

In a **Care Under Fire** situation the FMA:

- Must respond to suppression of hostile fire to minimize the risk of injury to personnel and minimize additional injury to previously injured UN members

In **Tactical Field Care** the FMAs:

- Must maintain security and situational awareness while continuing to tend to casualties and prepare for evacuation

## PRINCIPLES AND APPLICATIONS OF TFMA

# ROLES AND RESPONSIBILITIES OF FMA

### **First Responder Care (Role 1)**

The first medical care that UN personnel receive is provided at Role 1 (also referred to as unit-level medical care or self-aid, buddy aid, combat lifesaver, and/or medic care). This role of care includes:

- Immediate lifesaving measures and treatment for disease and non-battle injury (DNBI) or degradation of functional capability sustained by personnel and caused by factors other than those directly attributed to combat action

## PRINCIPLES AND APPLICATIONS OF TFMA

# THE KEY FACTORS INFLUENCING TFMA

- Hostile fire
- Tactical considerations
- Environmental considerations
- Wounding patterns
- Equipment constraints
- Delays in reaching higher levels of care
- Level of first responder training and experience

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## PRINCIPLES AND APPLICATIONS OF TFMA

# IMPORTANCE OF TFMA TRAINING

TFMA focuses on identifying and treating the causes of preventable death on the battlefield

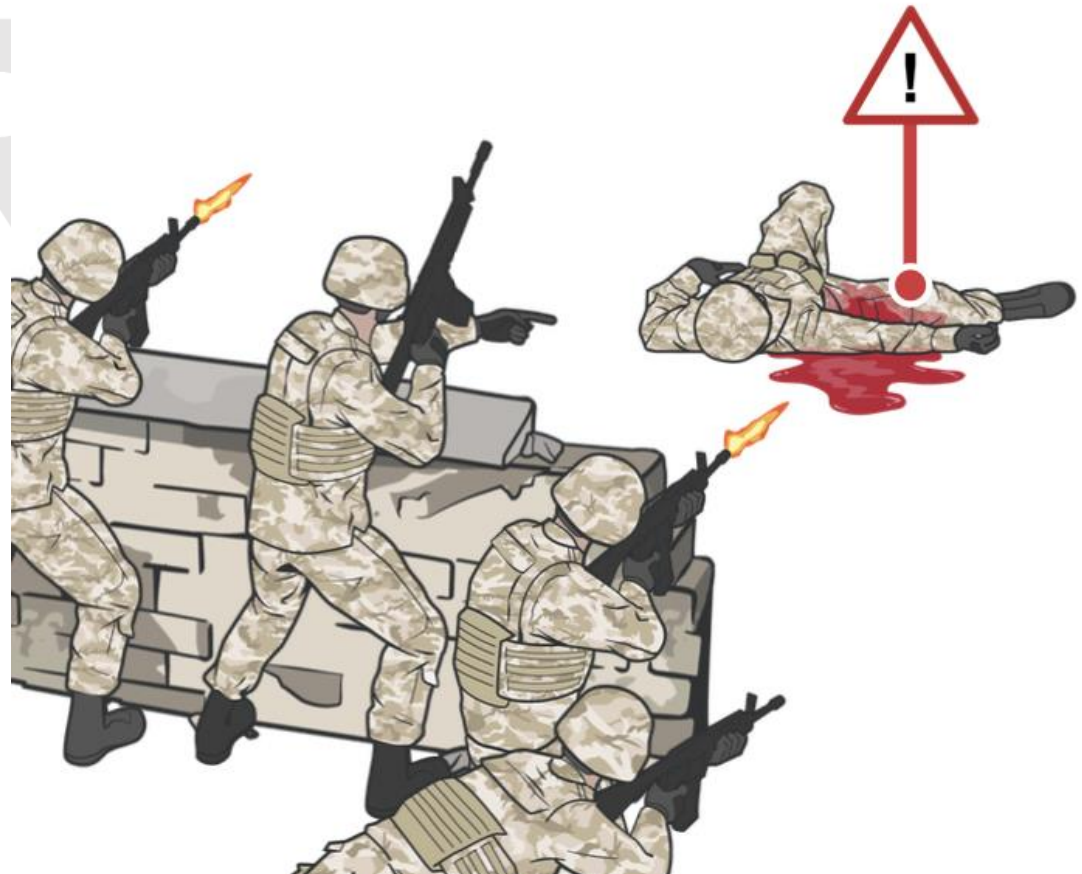
- Bleeding from arm and leg injuries
- Junctional bleeding where an arm or leg joins the torso such as the groin
- Noncompressible bleeding such as a gunshot wound to the abdomen
- Tension pneumothorax (**air trapped in the chest that prevents breathing and circulation**)
- Airway problems



## PRINCIPLES AND APPLICATIONS OF TFMA

### THREE GOALS OF TFMA

- Treat the casualty
- Prevent additional casualties
- Complete the mission



## ENTER PEACEKEEPING OPERATIONS

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## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

**NOTE: This is covered in more advanced TFMA training!**



## PHASE 1: CARE UNDER FIRE

### RETURN FIRE AND TAKE COVER

- Never attempt to rescue a casualty until hostile fire is suppressed
- Using available resources, ensure scene safety

### DIRECT CASUALTY TO REMAIN ENGAGED

**APPLY SELF-AID AND  
MOVE TO COVER** *(if able)*

### GAIN FIRE SUPERIORITY

**MOVE TO CASUALTY**  
*(if casualty is unable to  
move to cover)*



## PHASE 1: CARE UNDER FIRE

### APPLY TOURNIQUET TO CONTROL LIFE- THREATENING BLEEDING

For life-threatening bleeding, place a tourniquet "high and tight" above the wound

CONTINUE TO MAINTAIN  
FIRE SUPERIORITY

MOVE CASUALTY

### IMPORTANT CONSIDERATIONS:

Continuously assess risks and make a plan before moving a casualty



## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**M**ASSIVE BLEEDING

**A**IRWAY

**R**ESPIRATION

**C**IRCULATION

**H**YPOTHERMIA / HEAD INJURIES

### *AFTER* LIFE-THREATENING

**P**AIN

**A**NTIBIOTICS

**W**OUNDS

**S**PLINTING

## PHASE 2: OTHER CONSIDERATIONS OF TACTICAL FIELD CARE

### TFC

- The casualty and the person rendering care are not under direct fire
- Intervention priorities should follow MARCH PAWS

### LIMITED SUPPLIES

- Medical equipment and supplies awareness are limited to what is carried into the field by the FMA and the individual Service member

### REMEMBER:

- Always use the casualty's Buddy First Aid Kit (BFAK) first
- TFC can turn into a CUF situation unexpectedly
- Personnel should maintain their situational awareness

## PHASE 3: TACTICAL EVACUATION CARE

### CASUALTY MONITORING

- Continue to reassess and monitor casualty

### EVAC REQUEST

- Use UN Evacuation 4 Liner

### COMPLETE REPORT

- M**echanism of injury
- I**njuries
- S**ymptoms
- T**reatment

### CASUALTY PREP

- Prep Litter
- Prep Evac Equipment
- Pack Casualty
- Secure Items

### PRE-EVAC PROCEDURES

- Complete Casualty Card

(4 Line Format)

Line	UN CASEVAC 4-LINE ALERT MESSAGE		
	DTG:		
1	LOCATION AND CALL SIGN	PLACE NAME / DESCRIPTION	A
		GPS GRID REFERENCE	B
		CALL SIGN OF INCIDENT SITE COMMANDER	C
2	INCIDENT DETAILS	WHAT HAS HAPPENED? (Shooting, road accident, explosion etc).	D
		HOW MANY CASUALTIES ARE THERE?	E
3	ACTIONS BEING TAKEN AT SCENE	TREATMENT BEING GIVEN AND PREPARATIONS FOR EVACUATION	
4	RESOURCES REQUIRED AT SCENE TO TREAT AND EVACUATE PATIENT	GROUND AMBULANCE, AIR EVACUATION, AMET	

## IN SUMMARY

### GOALS

Treat the casualty

Prevent additional casualties

Complete the mission

### Three PHASES of TFMA

**1** CUF

RETURN FIRE  
AND TAKE COVER

- Quick decision-making:
- Consider scene safety
  - Identify and control life-threatening bleeding
  - Move casualty to safety

**2** TFC

COVER AND  
CONCEALMENT

- Basic Management Plan:
- Maintain tactical situational awareness
  - Triage casualties as required
  - MARCH PAWS assessment

**3** TEC

- More deliberate assessment and treatment of unrecognized life-threatening injuries:
- Pre-evacuation procedures
  - Continuation of documentation

## CHECK ON LEARNING

- What factors influence TFMA?
- What are the phases of care in TFMA?
- What is the most essential treatment task in CUF?
- What is every first responder's role in CUF?
- What does MARCH PAWS stand for?



## FIELD MEDICAL ASSISTANT COURSE (FMAC)

# **MODULE 02: MEDICAL EQUIPMENT**

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor



## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

### **TO3** Describe the use of individual medical equipment components in accordance with TFMA Guidelines

- EO9** Describe the use of a first aid kit in accordance with UN policy.
- EO10** Identify the contents of an individual Buddy First Aid Kit (BFAK), and/or other UN specific first aid kits.
- EO11** Describe the general maintenance and resupply procedures for trauma materials in a first aid kit in accordance with UN guidelines.
- EO12** Identify the contents of a UN Trauma Pack (UNTP), and/or other UN specific first aid kits.
- EO13** Describe the use of the components of a UN Trauma Pack (UNTP) in accordance with UN policy

## MEDICAL EQUIPMENT

# MEDICAL SUPPLIES

## WHAT YOU WILL NEED TO PROVIDE AID AND SAVE A LIFE:

### Medic Pack

UN Trauma Pack (UNTP)



### Individual

Buddy First Aid Kit (BFAK)



BE FAMILIAR WITH YOUR INDIVIDUAL AND  
UN/UNIT-SPECIFIC MEDICAL EQUIPMENT!



## MEDICAL EQUIPMENT CONTENT LIST

### Medic Pack

UN Trauma Pack (UNTP)

See Handbook

### Individual

Buddy First Aid Kit (BFAK)

See Handbook

## MEDICAL EQUIPMENT CONTENT OVERVIEW

### TOURNIQUET

A device to stop **massive** bleeding



### HEMOSTATIC GAUZE

Gauze rolls used to stop **major life-threatening** bleeding



### EMERGENCY BANDAGE/ TRAUMA DRESSING

Elastic bandage used as a **pressure** dressing and/or **standard** dressing



## MEDICAL EQUIPMENT CONTENT OVERVIEW

### NASOPHARYNGEAL AIRWAY (NPA) WITH WATER-BASED LUBRICANT

Nonsterile, rubber tube-shaped device that can be inserted into the casualty's nostril



### VENTED CHEST SEAL

Vented and adhesive chest seal for treating **penetrating wounds** to the **chest**



### NDC 10-14 GAUGE 3.25” NEEDLE CATHETER

Catheter-over-needle device that can be inserted into the casualty's chest to **treat tension pneumothorax**



## MEDICAL EQUIPMENT CONTENT OVERVIEW

1. Moxifloxacin 400mg tablet
2. Meloxicam 15mg tablet
3. Acetaminophen x2 650mg



### NOTE:

- **Each** of the three medications (in unit dosages) is contained in a **single blister pack**
- The Combat Wound Medication Pack (**CWMP**) is an **example of medication that might** be used **ONLY** for traumatic injuries and **ALL** penetrating injuries.
- **Drugs should only be administered by trained medical personnel**

## MEDICAL EQUIPMENT CONTENT OVERVIEW

### GAUZE/PACKING DRESSING

Gauze rolls used to **stop minor bleeding** or as **bulky material** for packing wounds



### ELASTIC BANDAGE

Stretchable bandage that **creates localized pressure** used for pressure dressings





## MEDICAL EQUIPMENT CONTENT OVERVIEW

**ACTIVE**



**PASSIVE**





### ACTIVE/PASSIVE HYPOTHERMIA BLANKET

Used to prevent and manage hypothermia



## MEDICAL EQUIPMENT DOCUMENTATION

**MACE 2**  
Military Acute Concussion Evaluation



Use MACE 2 as close to time of injury as possible.

Service Member Name: \_\_\_\_\_

DoD/EDIPI/SSN: \_\_\_\_\_ Branch of Service & Unit: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

Examiner: \_\_\_\_\_

Date of Evaluation: \_\_\_\_\_ Time of Evaluation: \_\_\_\_\_

**Purpose:** MACE 2 is a multimodal tool that assists providers in the assessment and diagnosis of concussion. The scoring, coding and steps to take after completion are found at the end of the MACE 2.

**Timing:** MACE 2 is most effective when used as close to the time of injury as possible. The MACE 2 may be repeated to evaluate recovery.

**RED FLAGS**

Evaluate for red flags in patients with Glasgow Coma Scale (GCS) 13-15.

<input type="checkbox"/> Deteriorating level of consciousness	<input type="checkbox"/> Results from a structural brain injury detection device (if available)
<input type="checkbox"/> Double vision	<input type="checkbox"/> Seizures
<input type="checkbox"/> Increased restlessness, combative or agitated behavior	<input type="checkbox"/> Weakness or tingling in arms or legs
<input type="checkbox"/> Repeat vomiting	<input type="checkbox"/> Severe or worsening headache

**Defer MACE 2 if any red flags are present. Immediately consult higher level of care and consider urgent evacuation according to evacuation precedence/Tactical Combat Casualty Care (TCCC).**

☐ **Negative for all red flags**  
Continue MACE 2, and observe for red flags throughout evaluation.

Revised 10/2018      dvbic.dcoe.mil      Page 1 of 14

### MILITARY ACUTE CONCUSSION EVALUATION (MACE2)

Used for identifying **possible traumatic brain injury (TBI)**

## MEDICAL EQUIPMENT CONTENT OVERVIEW

### RIGID EYE SHIELD

A shield that provides a domed **protection** of **eye injuries WITHOUT** applying pressure



### MALLEABLE SPLINTING

Semirigid material that can be formed to the injured limb to assist in immobilizing



### CRAVATS

Used to assist in immobilizing the injured limb or protrusion



# MEDICAL EQUIPMENT DOCUMENTATION

(4 Line Format)

Line	UN CASEVAC 4-LINE ALERT MESSAGE		
	DTG:		
1	LOCATION AND CALL SIGN	PLACE NAME / DESCRIPTION	A
		GPS GRID REFERENCE	B
		CALL SIGN OF INCIDENT SITE COMMANDER	C
2	INCIDENT DETAILS	WHAT HAS HAPPENED? (Shooting, road accident, explosion etc).	D
		HOW MANY CASUALTIES ARE THERE?	E
3	ACTIONS BEING TAKEN AT SCENE	TREATMENT BEING GIVEN AND PREPARATIONS FOR EVACUATION	
4	RESOURCES REQUIRED AT SCENE TO TREAT AND EVACUATE PATIENT	GROUND AMBULANCE, AIR EVACUATION, AMET	

## UN Evacuation 4 Liner

Call procedure that is divided into 4 lines of information for evacuation crews

## Cas Card

UN Approved casualty card

## MEDICAL EQUIPMENT MAINTENANCE AND RESUPPLY



### **REMEMBER:**

**Regularly** inspect your **BFAK**, **UNTP** and other service-specific medical kits:

- **BEFORE**
- **DURING**
- **AFTER**

**ALL** training events and missions

## MEDICAL EQUIPMENT MAINTENANCE AND RESUPPLY



Check to be sure all equipment is in the kit

Check **seals** and **wrappers**

- REPLACE items with **broken** or **unsealed** wrappers

Check **expiration** dates

- REPLACE if **expired** or the expiration date **DOES NOT** exceed your expected deployment timeframe

**BEWARE** OF EQUIPMENT THAT IS **NOT UN** APPROVED!

DO NOT DEPLOY WITH **MISSING, PREVIOUSLY USED FOR TRAINING, OR EXPIRED EQUIPMENT**

## UN TRAUMA PACK



AI



Always use the **casualty's** BFAK first

UN Trauma Pack

When supplies are exhausted from the casualty's BFAK, resort to using supplies from the UNTP

## SKILL STATION

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Familiarization with BFAK and UNTP



## MEDICAL EQUIPMENT SUMMARY



### **BUDDY AID**

UN Trauma Pack (UNTP)



### **INDIVIDUAL**

Buddy First Aid Kit (BFAK)

Familiarize yourself with the content of the UNTP and BFAK.

Ensure you are aware of the resupply procedures and how to maintain your equipment.

Regularly inspect your BFAK, UNTP, and other UN specific medical kits:

- **BEFORE**
- **DURING**
- **AFTER**

**ALL** training events and missions.

Be sure to use proper documentation when needed; MACE2, 4-Line, and Casualty Card.



## CHECK ON LEARNING

- When providing “buddy aid,” should you use your BFAK or the casualty’s BFAK?
- What is the most important lifesaving item in the BFAK?
- When should medications and medical-grade equipment be replaced in the BFAK?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## MODULE 03: **CARE UNDER FIRE**

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant



You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

### **TO4** Given a combat peacekeeping or non-combat peacekeeping scenario, perform Care Under Fire in accordance with TFMA Guidelines

- EO14** Describe the role of fire superiority and threat containment on TFMA.
- EO15** Describe the actions required before engaging with a casualty to prevent harm or additional casualties in accordance with TFMA guidelines.
- EO16** Identify appropriate actions and priorities to treat and move casualties in CUF.
- EO17** Identify the importance of early application of limb tourniquets to control life-threatening bleeding in CUF.
- EO18** Demonstrate one-handed tourniquet application to self in CUF.
- EO19** Demonstrate two-handed tourniquet application to a casualty in CUF.
- EO20** Describe the principles, advantages, and disadvantages of one-person drag/carry or two-person drag/carry in CUF.
- EO21** Demonstrate the one-person drags and carries of a casualty in CUF.
- EO22** Demonstrate two-person drags and carries of a casualty in CUF.

## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

**NOTE: This is covered in more advanced TFMA training!**



YOU ARE HERE

## PHASE 1: CARE UNDER FIRE

### RETURN FIRE AND TAKE COVER

- Never attempt to rescue a casualty until hostile fire is suppressed
- Using available resources, ensure scene safety

### DIRECT CASUALTY TO REMAIN ENGAGED

### APPLY SELF-AID AND MOVE TO COVER *(if able)*

### GAIN FIRE SUPERIORITY

### MOVE TO CASUALTY *(if casualty is unable to move to cover)*

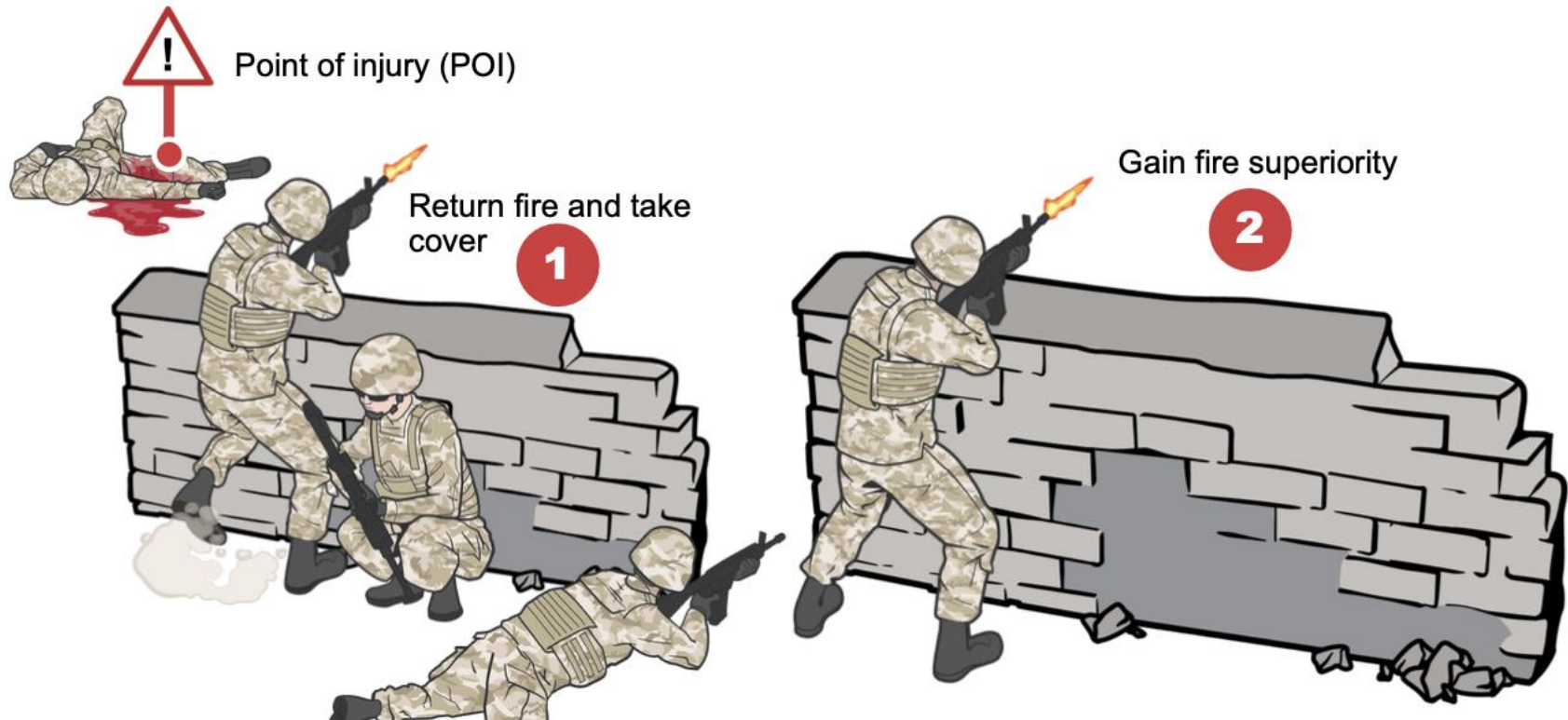
### IMPORTANT CONSIDERATIONS:

- **Order of actions** will be dictated by the situation
- A casualty **may** be able to perform **self-aid**
- **Constantly ASSESS risks** and make a plan **before** moving a casualty



## CARE UNDER FIRE

# ROLE OF FIRE SUPERIORITY

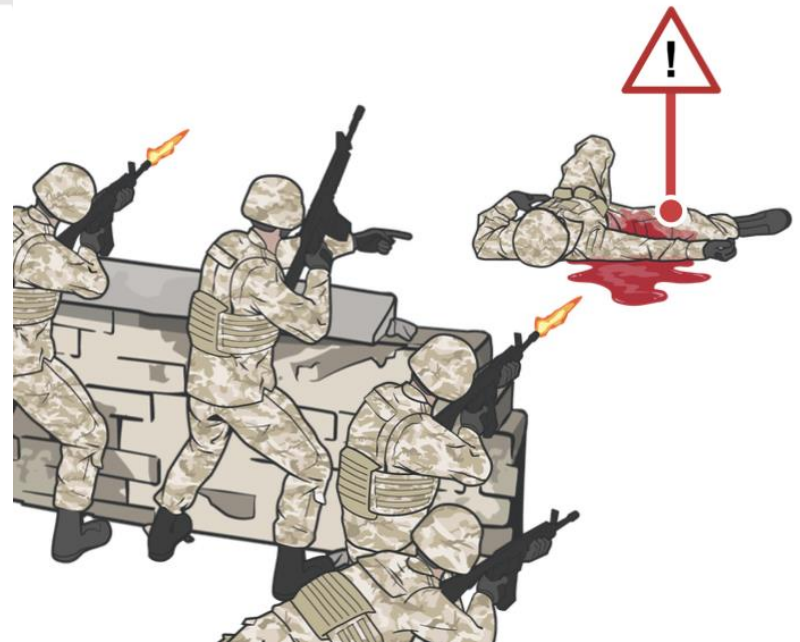


## CARE UNDER FIRE

# FIRE SUPERIORITY PRINCIPLES

- **Order of actions** will be dictated by the situation
- Return fire **AND** take cover
- **Direct casualty** to remain engaged
- **Direct casualty** to apply self-aid and move to cover
- DO NOT approach casualty while casualty is **inside of a KILL ZONE**
- **Suppress** hostile fire to gain fire superiority

Place a tourniquet on life-threatening bleeding and get the casualty **OUT** of the **KILL ZONE** if they are unable to move







## CARE UNDER FIRE CASUALTY SELF-AID



**Direct** casualty to return  
fire, if able

**Have** casualty move to cover  
and apply self-aid



## CARE UNDER FIRE

# IF CASUALTY IS UNABLE TO MOVE

If casualty is unable to move to cover, when **tactically feasible**, go to them when fire has been **SUPPRESSED** and fire superiority has been **GAINED** and **AID THEM IN MOVEMENT**

- Use rope, dragging straps, etc.





## CARE UNDER FIRE

### PHASE 1: CARE UNDER FIRE

#### APPLY TOURNIQUET TO CONTROL LIFE-THREATENING BLEEDING

- For life-threatening bleeding, place a tourniquet (TQ) "**high and tight**" above the wound

#### MOVE CASUALTY

- Drag or carry based on **tactical situation**





**MASSIVE BLEEDING**  
**IN**  
**CARE UNDER FIRE**

**DRAFT**

CARE UNDER FIRE

## CARE UNDER FIRE OVERVIEW

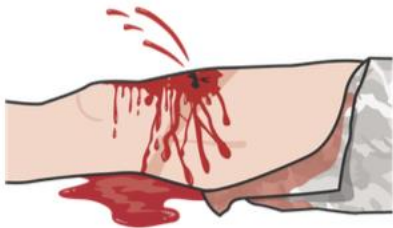
**CARE UNDER FIRE BLEEDING  
CONTROL**

Video can be found on [DeployedMedicine.com](https://DeployedMedicine.com)

## CARE UNDER FIRE

# IDENTIFY LIFE-THREATENING BLEEDING

- **Bright red blood** is pooling on the ground
- The overlying clothes are **soaked** with blood



- There is a traumatic **AMPUTATION** of an **arm** or **leg**



- There is a There is **pulsatile** (pulsing) or **steady** bleeding from the wound

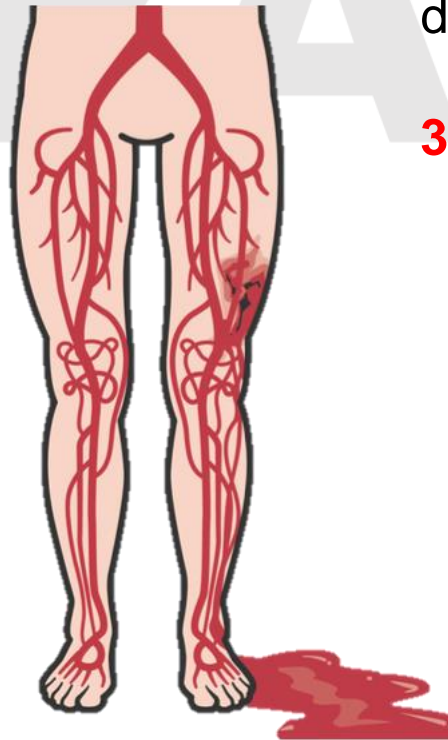
## QUESTION

# TIME TO BLEED OUT

How long does it take to **bleed to death** from a **major artery injury**?

Casualties with such an injury can bleed to death in *as little as*

**3 MINUTES**



## CARE UNDER FIRE

# KNOW YOUR ACCESS TO A TOURNIQUET

Have TQ available for self-application should you need one, **QUICK ACCESS IS KEY!**

- **DON'T** leave your TQ at the bottom of your pack!

### CASUALTY'S BFAK FIRST

- When helping a buddy, **NEVER USE YOUR OWN TQ** before the casualty's
- Look for the TQ in the **casualty's BFAK**
- If the casualty does **NOT** have a TQ available, **then** use the TQ from the UNTP or the next available one



BFAK



## CARE UNDER FIRE

# ONE-HANDED TOURNIQUET SELF-APPLICATION

### One-Handed Application

The one-handed application is normally used to apply a TFMA-recommended windlass TQ to the **upper extremities** (upper arm or forearm)

### WINDLASS TQ

- A **windlass** TQ is the TQ of choice; it is effective and can be applied quickly
- Use the windlass TQ from the BFAK





CARE UNDER FIRE

**ONE-HANDED WINDLASS**  
**TOURNIQUET APPLICATION**

**ONE-HANDED WINDLASS  
TOURNIQUET**

Video can be found on [DeployedMedicine.com](http://DeployedMedicine.com)

## CARE UNDER FIRE

# ONE-HANDED TOURNIQUET APPLICATION CRITICAL POINTS

### WINDLASS TQ

- TQ's are used to control massive or severe hemorrhage (bleeding) of an extremity (arms and legs)
- TQs are **effective** and can be **applied quickly**
- TQs are the most important lifesaving item in the BFAK and should be kept easily accessible

When helping a buddy, **NEVER USE YOUR OWN tourniquet** before the casualty's





# CARE UNDER FIRE

## BUDDY AID

### IF CASUALTY IS UNRESPONSIVE OR UNABLE TO MOVE

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Approach casualty and  
**conduct visual blood  
sweep** (looking for major  
bleeding)

**If you see bleeding**, apply  
a hasty (high and tight) TQ  
using a **two-handed  
method**



#### **IMPORTANT CONSIDERATION:**

Be sure to use equipment (TQ)  
in the casualty's BFAK and not your own

CARE UNDER FIRE

**TWO-HANDED WINDLASS**  
**TOURNIQUET APPLICATION**

**TWO-HANDED WINDLASS**  
**TOURNIQUET**

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)

## CARE UNDER FIRE

# SKILL STATION

### CUF Tourniquet (Skills)

- One-Handed (Windlass) TQ Application in CUF
- Two-Handed (Windlass) TQ Application in CUF

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## TACTICAL FIELD CARE

# EXTRACTION OF CASUALTIES

- Casualty to be extracted from vehicles and buildings per UN Standard Operating Procedure (SOP)
- **If casualties are on fire, put out the fire IMMEDIATELY**
- Move casualty to **relative safety** following the unit SOP



## CRITICAL OBJECTIVES FOR THE ONE- OR TWO- PERSON DRAG/CARRY



- Once bleeding is controlled, move the casualty to cover using a one- or two-person drag/carry
- At the point of injury you must move your casualty to the closest position of cover
- If you must move a casualty under fire, then quickly develop a casualty movement rescue plan
- When moving casualties, spinal injuries are not to be a concern during Care Under Fire movements





## DRAG/CARRY

### ONE-PERSON DRAG/CARRY



**SUPPORT CARRY** should be used for a conscious casualty only



**KIT OR ARM DRAG** Some body armour is equipped with a drag handle; therefore, no additional equipment is required



**NECK DRAG** also **limits** the casualty and rescuer from exposure to enemy fire



**CRADLE-DROP DRAG** is effective in moving a casualty **up or down the stairs, steps, or short distances**

CARE UNDER FIRE  
**ONE-PERSON**  
**CASUALTY DRAG/CARRY**

**ONE-PERSON DRAGS & CARRIES**

Video can be found on [DeployedMedicine.com](http://DeployedMedicine.com)

## DRAG/CARRY

# TWO-PERSON DRAG/CARRY



The **TWO-MAN SUPPORTING CARRY** can be used in transporting **both** conscious and unconscious casualties



**KIT OR ARM DRAG** can cause Injury to either the rescuer or casualty during training drills; keep safety in mind



**FORE AND AFT CARRY** Exposes two rescuers to hostile fire instead of one

CARE UNDER FIRE  
**TWO-PERSON**  
**CASUALTY DRAG/CARRY**

**TWO-PERSON DRAGS & CARRIES**

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)



## DRAG/CARRY SKILL STATION

### Drag/Carry (Skills)

- One-Person Drag/Carry
- Two-Person Drag/Carry

DRAFT

## CARE UNDER FIRE

# SUMMARY

- We defined Care Under Fire
- We discussed the importance of fire superiority
- We defined massive hemorrhage control methods
- We discussed casualty movement in CUF
- We discussed the advantages and disadvantages of one- and two-person drag/carry methods

## CHECK ON LEARNING

- What is Care Under Fire?
- What are the signs of life-threatening bleeding?
- How long does it take to bleed to death from a complete femoral artery and vein disruption?
- What are the advantages and disadvantages of one-person drags?
- What are the advantages and disadvantages of two-person carries?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## MODULE 04: **PRINCIPLES AND APPLICATION OF TACTICAL FIELD CARE (TFC)**



## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**TO5** Given a combat peacekeeping or non-combat peacekeeping scenario, perform Tactical Field Care in accordance with TFMA Guidelines

- EO23** Identify the importance of security and safety in Tactical Field Care (TFC)
- EO24** Identify basic principles of removal/extraction of casualties from a unit-specific platform
- EO25** Identify the importance and techniques of communicating casualty information with unit tactical leadership and/or medical personnel
- EO26** Identify the relevant tactical and casualty data involved in communicating casualty information
- EO27** Identify Demonstrate communication of casualty information to tactical leadership and/or medical personnel (in accordance with UN and/or unit standard operating procedures in TFC)
- EO28** Identify triage considerations in TFC

## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

**NOTE:** This is covered in more advanced TFMA training!



YOU ARE HERE



CASUALTY AND RESPONDER NO  
LONGER UNDER EFFECTIVE ENEMY  
FIRE OR THREAT  
ENTER INTO THE  
**TACTICAL FIELD CARE  
(TFC) PHASE**

## TACTICAL FIELD CARE

# PHASE 2: TACTICAL FIELD CARE

TFC IS CARE RENDERED WHEN NO  
LONGER UNDER EFFECTIVE ENEMY FIRE  
OR THREAT

Having transitioned from  
**Care Under Fire (CUF)**, further  
**assessment** and **care** can be  
more **deliberate** following the  
**MARCH PAWS** sequence

This does **NOT** mean that  
the danger is over – the  
tactical situation could  
**change** back to CUF **AT**  
**ANY TIME**

### IMPORTANT CONSIDERATIONS:

Mission personnel should  
**constantly maintain** their  
situational awareness of  
the **potential threat** from  
hostile forces

Tactical Field Care also encompasses  
combat/tactical environment not involving enemy  
fire (e.g., parachute injury in combat zone)

## TACTICAL FIELD CARE

# 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 HAVE

- Weapons **cleared** and **secured**
- **Communications** secured
- **Sensitive** items redistributed
- **Weapons** and **radios DO NOT** mix well with shock or narcotics



## TACTICAL FIELD CARE

# OTHER CONSIDERATIONS

TFC is when the casualty and the person rendering care are NOT under direct fire

### LIMITED SUPPLIES

Medical equipment and supplies are **LIMITED** to what is **carried** into the field by the FMA and the individual UN member

### REMEMBER:

- Always use the **casualty's** BFAK **FIRST**
- TFC can turn into a CUF situation **unexpectedly**
- Personnel should **maintain** their situational awareness



## TACTICAL FIELD CARE

# CASUALTY REMOVAL/EXTRACTION PRINCIPLES

- The first principle is safety. Safety is critical.
- The second principle of MARCH still applies. If possible, you may want to initiate lifesaving measures like applying a tourniquet before the extraction, and monitor them throughout the process.
- The third principle is training.



**Extractions will vary based on the mission and vehicles located in your Area of Responsibility (AOR)**



## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**M**ASSIVE BLEEDING **#1 Priority**

**A**IRWAY

**R**ESPIRATION

**C**IRCULATION

**H**YPOTHERMIA / HEAD INJURIES

### *AFTER* LIFE-THREATENING

**P**AIN

**A**NTIBIOTICS

**W**OUNDS

**S**PLINTING

## TACTICAL FIELD CARE COMMUNICATION



**Communicate** with the casualty, if possible

- **Encourage**
- **Reassure**
- **Explain care** each step of the way



**Communicate** with tactical leadership **IMMEDIATELY** on evacuation requirements

**Continue** to communicate with leadership on casualty treatment as needed

(4 Line Format)

UN CASEVAC 4-LINE ALERT MESSAGE			
Line	DTG:		
1	LOCATION AND CALL SIGN	PLACE NAME / DESCRIPTION	A
		GPS GRID REFERENCE	B
		CALL SIGN OF INCIDENT SITE COMMANDER	C
2	INCIDENT DETAILS	WHAT HAS HAPPENED? (Shooting, road accident, explosion etc).	D
		HOW MANY CASUALTIES ARE THERE?	E
3	ACTIONS BEING TAKEN AT SCENE	TREATMENT BEING GIVEN AND PREPARATIONS FOR EVACUATION	
4	RESOURCES REQUIRED AT SCENE TO TREAT AND EVACUATE PATIENT	GROUND AMBULANCE, AIR EVACUATION, AMET	

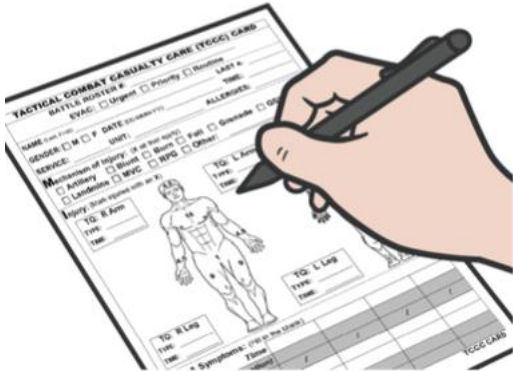
### COMMUNICATE WITH EVACUATION AND MEDICAL ASSETS

**Communicate** with the evacuation system to coordinate evacuation using the **4-Line CASEVAC request**

Keep each casualty's Cas Card up to date

## TACTICAL FIELD CARE

# COMMUNICATE RELEVANT CASUALTY DATA



**Document ALL** assessment and medical care (including interventions and medications) on the Casualty Card



**Communicate** with CASEVAC using the:

**4-Line** CASEVAC request form

**MIST** Report

**M**echanism of injury

**I**njuries

**S**ymptoms

**T**reatment

**Relay** the information following your standard operating procedures

### COMMUNICATE CASUALTY DATA IN HAND-OFF WITH MEDIC OR CASEVAC

When handing casualty off to medic or CASEVAC, read off the Casualty Card, including any additional information as needed

**MIST** report may **change** as the **casualty status** and **interventions** performed change

## TACTICAL FIELD CARE

# TRIAGE – PRIORITIZING MULTIPLE CASUALTIES

**Casualties with these injuries must be treated first:**

- #1 **Massive bleeding**
- #2 **Penetrating** trauma into the box (torso)
- #3 **Airway** compromise
- #4 **Respiratory** distress
- #5 Altered mental status



## TACTICAL FIELD CARE

# TRIAGE CONSIDERATIONS

- Casualties may need to be sorted into prioritized treatment groups
- The FMA may be required to assist medical personnel with urgent casualties, monitor casualties after emergency interventions, and may be tasked with preparing casualties for evacuation



## TACTICAL FIELD CARE SUMMARY

- Ensure you are aware of all security and safety procedures for TFC
- Tactical Field Care is when the casualty and the responder are both no longer under effective enemy fire or threat
- Security and safety in TFC is a priority; clear and secure weapons and communications
- Understand the principles of casualty extractions in accordance with unit standard operating procedures
- Always follow the MARCH PAWS procedure during life-threatening and after life-threatening injuries

## CHECK ON LEARNING

- What is the difference between the TFC and CUF phases?
- True or False: During TFC, the tactical situation could change back to CUF again at any time.
- What is MARCH PAWS?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

**MODULE 05:**

**TACTICAL TRAUMA ASSESSMENT (TTA)**



## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant



You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

### **TO6** Given a combat peacekeeping or non-combat peacekeeping scenario, perform Tactical Field Care in accordance with TFMA Guidelines

- EO29** Demonstrate the techniques used to assess a casualty for responsiveness.
- EO30** Identify the common causes of altered mental status in combat peacekeeping or non-combat peacekeeping environments
- EO31** Identify the importance of disarming and securing communications equipment of a casualty with altered mental status
- EO32** Identify the importance and techniques of communicating with a casualty in TFC
- EO33** Demonstrate communicating with a casualty in TFC
- EO34** Demonstrate application of body substance isolation (BSI) in TFC
- EO35** Demonstrate a TTA in the proper order using the MARCH PAWS sequence in accordance with TFMA Guidelines
- EO36** Demonstrate the appropriate actions and interventions used during a casualty assessment to render aid to the casualty in accordance with TFMA Guidelines

## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**M**ASSIVE BLEEDING **#1 Priority**

**A**IRWAY

**R**ESPIRATION

**C**IRCULATION

**H**YPOTHERMIA / HEAD INJURIES

### *AFTER* LIFE-THREATENING

**P**AIN

**A**NTIBIOTICS

**W**OUNDS

**S**PLINTING

# TACTICAL TRAUMA ASSESSMENT HOW-TO

## TACTICAL TRAUMA ASSESSMENT

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)

# COMBAT SPEED TTA “FIRE FIGHT CONSCIOUS CASUALTY”

## TACTICAL TRAUMA ASSESSMENT “Fire Fight Conscious Casualty”

Video can be found on [DeployedMedicine.com](http://DeployedMedicine.com)

## COMBAT SPEED TTA

### “FIRE FIGHT UNCONSCIOUS CASUALTY”

**TACTICAL TRAUMA ASSESSMENT**  
**‘Explosion’ Unconscious Casualty”**

Video can be found on [DeployedMedicine.com](http://DeployedMedicine.com)

## TACTICAL TRAUMA ASSESSMENT

# BODY SUBSTANCE ISOLATION (BSI)



Whenever possible, the responder should don latex-free gloves as a precaution

## CASUALTY BLOOD SWEEP

Your initial casualty evaluation should be a rapid head-to-toe check for any unrecognized life-threatening bleeding

- Check the neck, axillary (armpit), inguinal (groin)
- Check the legs, arms, abdomen, chest (in a raking motion) and back





# MASSIVE BLEEDING

## QUICKLY IDENTIFY

### MASSIVE, LIFE-THREATENING BLEEDING

**BRIGHT RED BLOOD**  
is pulsing or spurting, or  
there is steady bleeding  
from the wound



Overlying clothing or ineffective  
bandaging is becoming  
**SOAKED WITH BLOOD**



**BRIGHT RED BLOOD**  
is pooling on the  
ground



**AMPUTATION** of  
the arm or leg

**IMPORTANT!** Casualties with  
severe injuries can bleed to  
death in *as little as 3 minutes*

**M A R C H**

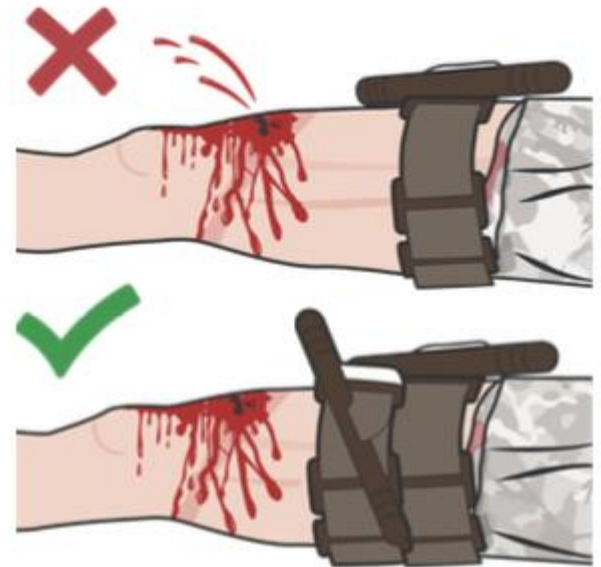
## MASSIVE HEMORRHAGE CONTROL IN TFC

### HEMORRHAGE CONTROL

Assess for other sources of hemorrhage, and control all life-threatening bleeding



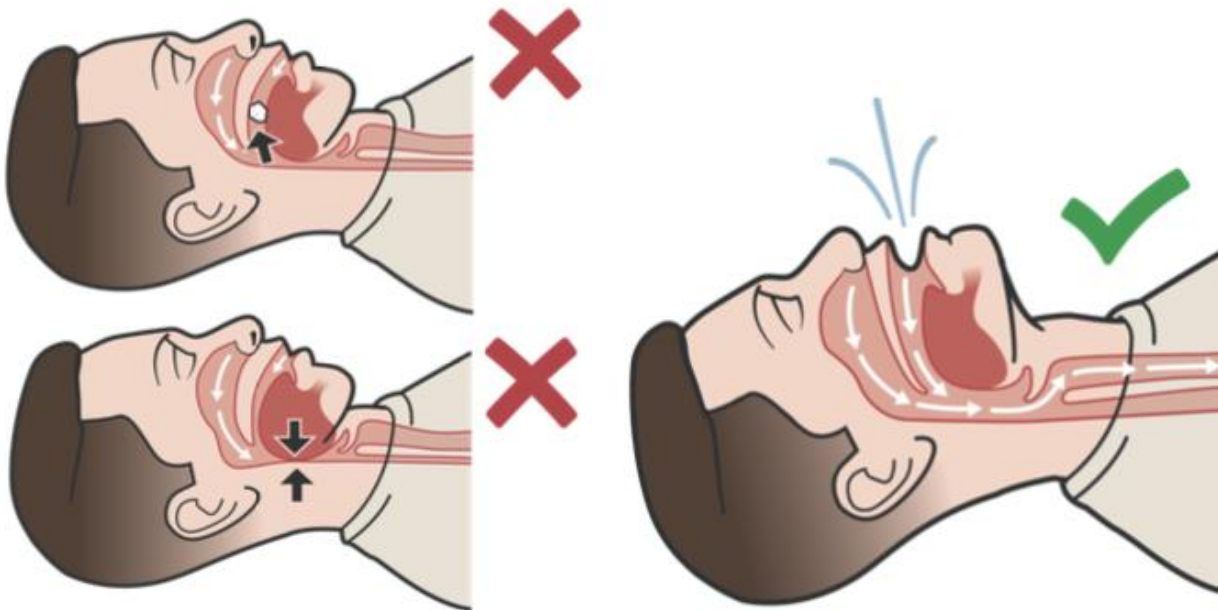
If not already done, where appropriate, use a TFMA recommended limb tourniquet (TQ) to control life-threatening external hemorrhage, applying it 2-3 inches above the source of bleeding, directly on the skin



Reassess CUF interventions, and If bleeding is not controlled with the first TQ, apply a second TQ side-by-side with the first

## AIRWAY MANAGEMENT

# IDENTIFYING OBSTRUCTED AIRWAY



**IMPORTANT!** Remove any visible objects, but do not perform a blind finger sweep

**MARCH**

### SIGNS AND SYMPTOMS AIRWAY MAY BE BLOCKED:

- Casualty is in distress and indicates they can't breathe properly
- Casualty is making snoring or gurgling sounds
- Visible blood or foreign objects are present in the airway
- Maxillofacial trauma (severe trauma to the face) is observed

## OPENING THE AIRWAY

# IN A **CASUALTY** WITHOUT AN AIRWAY OBSTRUCTION, YOU CAN PERFORM THE FOLLOWING MANEUVERS:

### HEAD-TILT CHIN-LIFT

### JAW THRUST

**Unconscious** casualty's tongue may have relaxed, causing the tongue to block the airway by sliding to the back of the mouth and covering the opening to the windpipe



If you suspect that the casualty has suffered a neck or spinal injury, use the jaw-thrust method

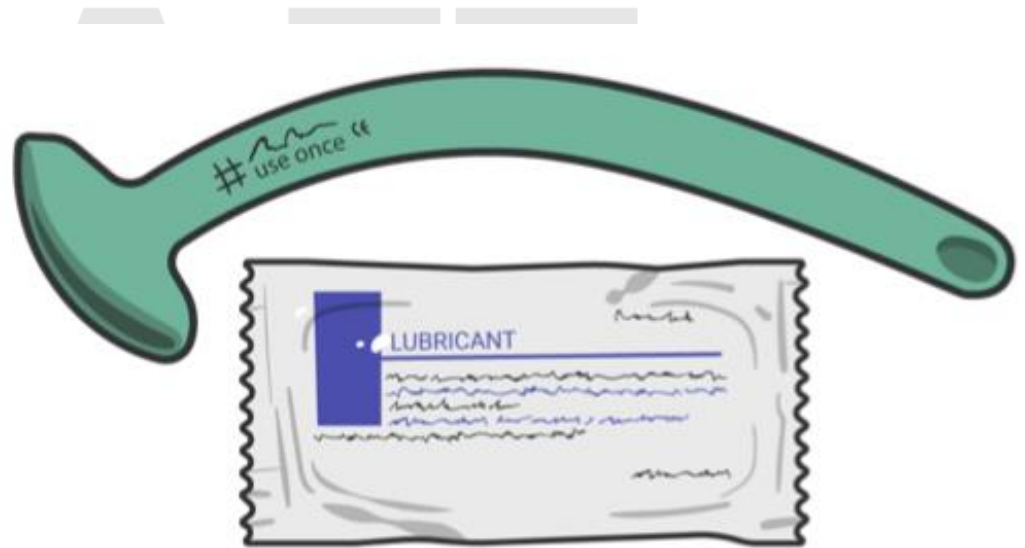
# M **A** R C H

## OPENING THE AIRWAY

# MANAGING THE AIRWAY

**I**F the casualty is breathing on their own but unconscious or semiconscious **AND** there is no airway obstruction, further airway management is best achieved with a nasopharyngeal airway (NPA)

An NPA can be used on a conscious or unconscious casualty to help open/maintain an open airway



**MARCH**

## MANAGING THE AIRWAY

# MANAGEMENT/RECOVERY POSITION



Casualties with **severe facial trauma** can often protect their own airways by sitting up and leaning forward



Assist a conscious casualty by helping them assume any comfortable sitting-up position that **ALLOWS THEM TO BREATHE EASILY**



For an unconscious casualty not in shock, place them into the **RECOVERY POSITION**

# MARCH



## TACTICAL TRAUMA ASSESSMENT

# RESPIRATIONS



Breathing rate  
(Monitor respirations)

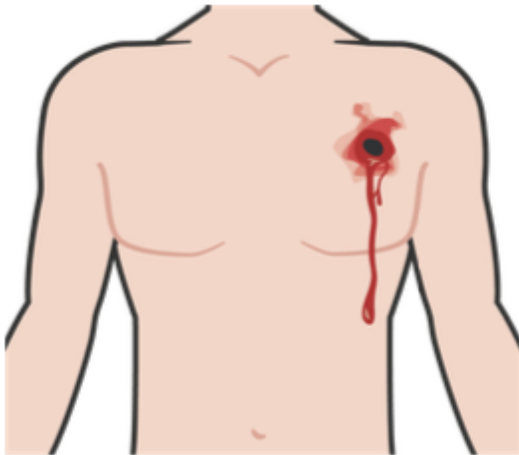


Level of consciousness

**M A R C H**

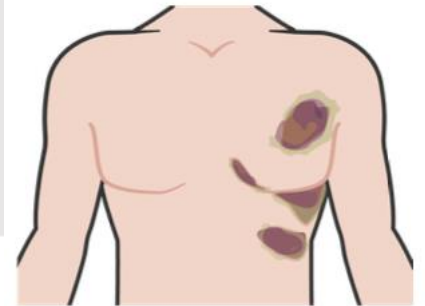
## TRE SPIRATION ASSESSMENT AND MANAGEMENT IN TFC

# LIFE- THREATENING CHEST INJURY



Expose the chest to assess for:

- Gunshot or shrapnel wound
- Blunt-force trauma
- Bruising or contusions
- Any deformities of the chest



If penetrating trauma is found  
or identified, apply a chest seal  
(vented, if available)

# M A R C H



## CIRCULATION

# REASSESS TREATMENTS

**M**



Reassess **ALL** treatment  
for **M**assive hemorrhage

**A**



Reassess **A**irway

**R**



Reassess **R**espirations

# MARCH

## CIRCULATION

# GENERAL INDICATOR OF SHOCK

## SIGNS AND SYMPTOMS OF SHOCK INCLUDE:

- Mental confusion
- Rapid breathing
- Sweaty, cool, clammy skin
- Pale/grey skin
- Weak or absent radial pulse
- Nausea
- Excessive thirst
- Previous severe bleeding



M A R C H

## HYPOTHERMIA

# HYPOTHERMIA PREVENTION

**Place the casualty on an insulated surface as soon as possible**

- Hypothermia is much easier to prevent than to treat! Begin hypothermia prevention as soon as possible
- Decreased body temperature interferes with blood clotting and increases the risk of bleeding
- Blood loss can cause a significant drop in body temperature, even in hot weather



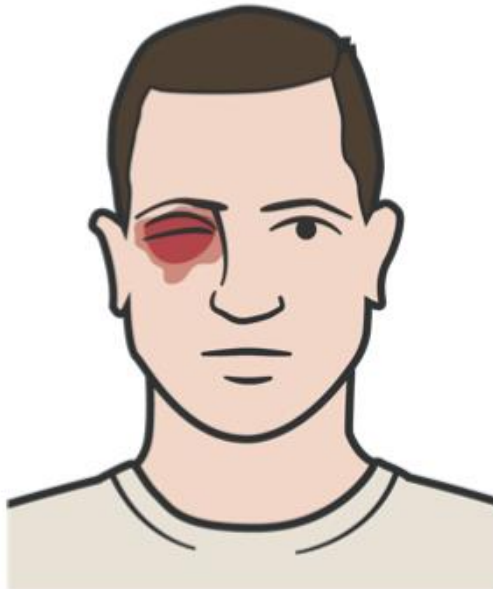
### **REMEMBER:**

Hypothermia is an issue even in hot environments and must be prevented

# M A R C H

## EYE INJURIES

# IF A **PENETRATING EYE INJURY** IS NOTED OR SUSPECTED



**Do not cover both eyes unless both eyes are injured**

- In the absence of an eye shield, consider using tactical eyewear



## PENETRATING INJURIES

# WOUND MEDICATION PACK (WMP)



Acetaminophen is used for pain management



Meloxicam can give significant pain relief and will not alter the casualty's mental status



Moxifloxacin contains oral antibiotic medication

**MARCH**  
**PAWS**

**MARCH**  
**PAWS**

### Remember:

- Medics carry medications
- Document all medications administered on the UN Casualty Card

## TACTICAL FIELD CARE GUIDELINES

# INSPECT AND ADDRESS KNOWN WOUNDS

Dress all known wounds and then assess all applied bandages for:

- Increased pain
- Skin discoloration
- Irregular pulse

**If any of these conditions are found, they might indicate an emergency!**

Ensure the applied bandage **isn't too tight**; loosen as needed while keeping the bleeding controlled



# DO NOT EVER APPLY IT AND FORGET IT!

## MARCH PAWS

## SECONDARY INJURIES

### BURN CARE



#### EXTRACT

Extract from burning vehicle, building, or area

**STOP THE BURNING PROCESS**



#### COVER

Cover the burn area with dry, sterile dressings for general burns



#### WHITE PHOSPHORUS = WET DRESSING

Eliminate wound contact with oxygen

Be sure to assess MARCH before burn care



## SECONDARY INJURIES

# ASSESS FOR A FRACTURE

### WARNING SIGNS

#### OF A FRACTURE:

- Significant pain and swelling
- An audible or perceived “snap”
- Different length or shape of limb
- Loss of pulse or sensation in the injured arm or leg (check pulse before and after treatment)
- Crepitus (hearing a crackling or popping sound under the skin)



**CLOSED FRACTURE**



**OPEN FRACTURE**



## TACTICAL FIELD CARE COMMUNICATION



Communicate with the casualty and if possible

- Encourage
- Reassure
- Explain care each step of the way



Communicate with tactical leadership as soon as possible with status and evacuation requirements throughout casualty treatment as needed

### COMMUNICATE WITH EVACUATION AND MEDICAL ASSETS

- Communicate with the evacuation system to coordinate CASEVAC using the 4-Line CASEVAC request
- Keep the Casualty Card

## TACTICAL EVACUATION

### PHASE 3: TACTICAL EVACUATION CARE

#### CASUALTY MONITORING

Continue to reassess and monitor casualty

#### EVAC REQUEST

Use 4-Line format

#### CASUALTY PREP

- Secure items
- Prep litter
- Prep evac equipment
- Pack casualty

#### COMPLETE MIST REPORT

- M** Mechanism of injury
- I** Injuries
- S** Symptoms
- T** Treatment

#### PRE-EVAC PROCEDURES

- Complete Casualty Card

# TRAINER-LED DEMONSTRATION

Tactical Trauma Assessment

DRAFT

## TACTICAL TRAUMA ASSESSMENT SUMMARY

- We defined Tactical Trauma Assessment
- We discussed assessing the casualty using MARCH PAWS
- We discussed proper communication and documentation



## CHECK ON LEARNING

- During which phase of care is the TTA performed?
- What mnemonic is used to prioritize care during the TTA?
- What is a blood sweep?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

DRAFT

MODULE 06:

## MASSIVE HEMORRHAGE CONTROL

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant



You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**TO7** Given a combat peacekeeping or non-combat peacekeeping scenario, perform massive hemorrhage control during Tactical Field Care in accordance with TFMA Guidelines

- EO37** Identify life-threatening hemorrhage (bleed)
- EO38** Identify the importance of early application of limb tourniquets to control life-threatening bleed
- EO39** Identify anatomical sites for applying direct and indirect pressure to control bleeding
- EO40** Demonstrate the appropriate application of a TFMA-recommended limb tourniquet
- EO41** Identify risks associated with applying an improvised limb tourniquet
- EO42** Demonstrate the application of a TFMA-recommended hemostatic dressing
- EO43** Demonstrate an evaluation of previously applied tourniquets for hemorrhage control effectiveness
- EO44** Demonstrate improvised junctional hemorrhage control with hemostatic dressing and direct pressure



## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

**NOTE:** This is covered in more advanced TFMA training!



YOU ARE HERE

## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

➤ **MASSIVE BLEEDING** #1 Priority

**A**IRWAY

**R**ESPIRATION

**C**IRCULATION

**H**YPOTHERMIA / HEAD INJURIES

### *AFTER* LIFE-THREATENING

**P**AIN

**A**NTIBIOTICS

**W**OUNDS

**S**PLINTING



## HEMORRHAGE OVERVIEW IN TFC

### HEMORRHAGE CONTROL IN TACTICAL FIELD CARE

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)

## TACTICAL FIELD CARE

# SECURITY AND SAFETY IN TACTICAL FIELD CARE

- **Establish** a security perimeter in accordance with UN tactical standard operating procedures (SOPs) and/or battle drills
- **Maintain** tactical situational awareness

### CASUALTIES WITH ALTERED MENTAL STATUS SHOULD HAVE

- **Weapons** cleared and secured
- **Communications** secured
- **Sensitive items** redistributed
- **NOTE:** Weapons and radios **DO NOT** mix well with **shock** or **narcotics**



## TACTICAL FIELD CARE

# PRIORITIZING **MULTIPLE** CASUALTIES

Casualties with these injuries must be treated first:

- #1 **Massive bleeding**
- #2 **Penetrating** trauma into the box (torso)
- #3 **Airway** compromise
- #4 **Respiratory** distress
- #5 **Altered** mental status



## WHEN IS BLEEDING LIFE-THREATENING?

### EARLY CONTROL OF SEVERE HEMORRHAGE IS **CRITICAL**



- **BRIGHT RED BLOOD** is pooling on the ground
- The **overlying clothes** are **SOAKED** with blood



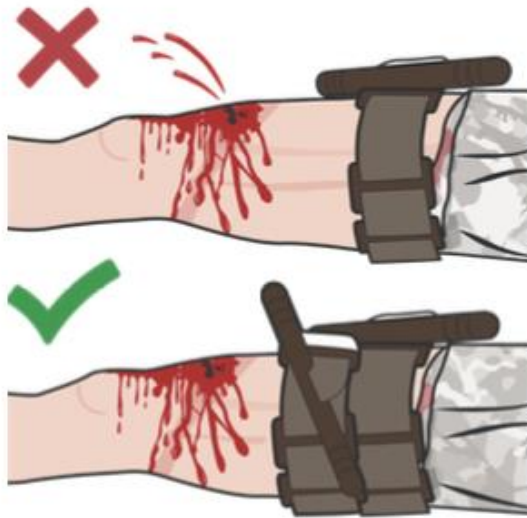
- There is **pulsatile** (pulsing) or **steady** bleeding from the wound



- Bandages or makeshift bandages used to cover the wound are **INEFFECTIVE** and steadily becoming **soaked** with blood
- There is a traumatic **amputation** of an arm or leg

## MASSIVE HEMORRHAGE CONTROL

# MASSIVE HEMORRHAGE REASSESSMENT



- **Reassess** any interventions performed in CUF
- If a tourniquet was previously applied, **assess** for effectiveness (bleeding has stopped and distal pulses are absent)
- If **ineffective**, apply a second tourniquet **side-by-side** with the first
- Perform a **blood sweep** and **expose** the casualty to look for other **life-threatening bleeding**, stopping to immediately treat anything identified, and look for non-life-threatening bleeding to address later

## MASSIVE HEMORRHAGE CONTROL

# TOOLS FOR LIFE-THREATENING HEMORRHAGE CONTROL

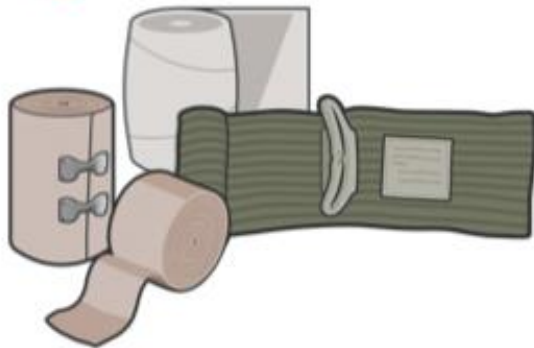
Direct pressure



- TFMA-recommended tourniquet



hemostatic dressing  
and pressure  
bandages



Pressure Delivery  
Device (PDD)



- Gauze/other dressings and pressure bandages



## MASSIVE HEMORRHAGE CONTROL

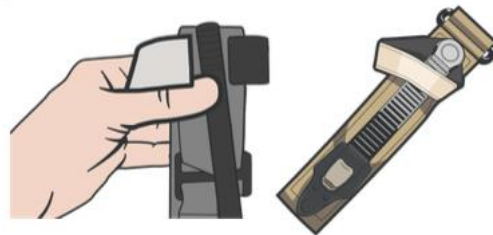
# INITIAL DIRECT PRESSURE BEFORE INTERVENTION

- **Direct pressure** can and **should be used** as a temporary measure **until** a **tourniquet or dressing is in place**
- It is difficult to use direct pressure alone to control significant bleeding or while moving the casualty
- Direct pressure can be **used** if a treatment no longer maintains control of the bleeding **while a new treatment is started**



## MASSIVE HEMORRHAGE CONTROL

# TOURNIQUETS



- The TQ that should be used as the **FIRST option** is the **CASUALTY'S TQ** from **THEIR own BFAK**
- If this is not possible, or more than one tourniquet is needed, then you may apply the TQ from your own BFAK or a TQ from unit mission equipment
- You should have a **new TQ** in your BFAK. It is designed as a **ONE-TIME USE DEVICE**

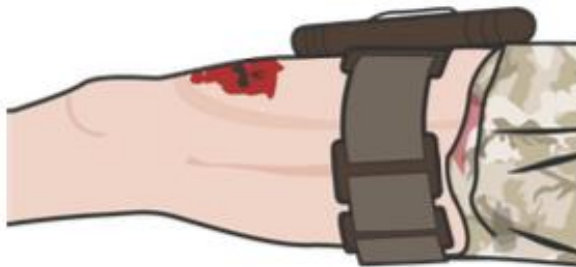
- A device stopping the flow of blood to an arm or leg by applying circumferential (around) pressure to the limb



## MASSIVE HEMORRHAGE CONTROL

# DELIBERATE TOURNIQUETS

- A TQ applied in **CUF** should be **reassessed**



- A TQ applied in TFC will be a **deliberate** TQ, applied **2-3 inches above the wound**, directly on the skin (not over clothing)
- In TFC the **source of bleeding** can be **identified** to ensure that TQs are properly placed



- TQs applied during **CUF** are **sometimes inadequate** due to the inability to properly expose and assess the wound, and application of an additional **side-by-side** TQ may be necessary

## MASSIVE HEMORRHAGE CONTROL

# TOURNIQUETS IN TACTICAL FIELD CARE

- Use a TQ to control life-threatening external hemorrhage that is anatomically amenable to TQ use or for **ANY traumatic amputation**



- Time should be documented during the TFC phase, not the CUF phase



- Apply directly to the skin 2-3 inches above the bleeding site
- If bleeding is **NOT** controlled with the first TQ, apply a second TQ **side-by-side** with the first

- **TQs need to be applied rapidly.** The bleeding should be stopped **WITHIN ONE MINUTE** and the TQ fully secured within three minutes
- TQ application time is **important** in helping medical personnel manage TQs

## MASSIVE HEMORRHAGE CONTROL

### TOURNIQUETS **EFFECTIVENESS** CHECKS



**TQs can be assessed for effectiveness by:**

- Ensuring that the **BLEEDING HAS STOPPED**
- Checking a pulse **distally** (further out) on the limb where the TQ is applied to ensure there is **NO PULSE**

MASSIVE HEMORRHAGE CONTROL

# TWO-HANDED WINDLASS TFC

**TWO-HANDED  
WINDLASS TOURNIQUET**

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)



## MASSIVE HEMORRHAGE CONTROL

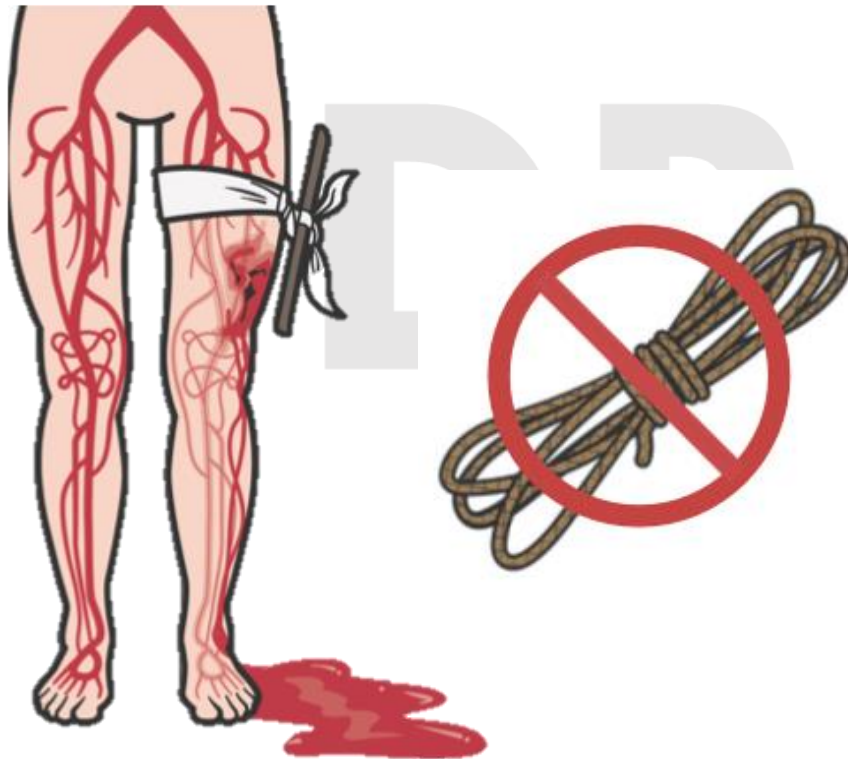
# TOURNIQUET PITFALLS/MISTAKES

- **NOT** using one when you should or waiting too long to put it on
- **NOT** pulling all the slack out before tightening
- **NOT** making it tight enough – the TQ should stop the bleeding AND eliminate the distal pulse
- **NOT** using a second TQ, if needed
- Using a TQ for minimal bleeding; however, **when in doubt**, apply a TQ
- Putting it on too proximally (too high) if the bleeding site is clearly visible
- Loosening TQs for a period to allow recirculation of a limb
- Taking it off (this should be performed **ONLY** by **medical personnel** at a **higher level of care**)
- **DON'T** put TQs over joints!



## RISKS WHEN USING IMPROVISED TOURNIQUETS

# DON'T USE AN IMPROVISED TOURNIQUET!



- If no TQ is available, **pack the wound** and hold **direct pressure** over the main source of bleeding

### RISKS ASSOCIATED WITH IMPROVISED TOURNIQUETS:

- **DAMAGE** may occur to skin if the band is too narrow
- Bleeding may **WORSEN**
- Bleeding **MAY NOT BE COMPLETELY CONTROLLED**
- An improvised TQ may likely **LOOSEN** over time from not being properly secured



## MASSIVE HEMORRHAGE CONTROL SKILL STATION

### TFC Hemorrhage Control (Skills)

- Two-Handed Windlass Tourniquet Application in TFC

DRAFT

## MASSIVE HEMORRHAGE CONTROL

# HEMOSTATIC DRESSING

- TFMA-recommended hemostatic dressing is safe and contains active ingredients that assist with blood-clotting at the bleeding site
- Hemostatic dressing can also be used for controlling bleeding in conjunction with tourniquets
- A BFAK contains one hemostatic dressing and one dry sterile gauze



## MASSIVE HEMORRHAGE CONTROL

### HEMOSTATIC DRESSING



- **Hemostatic dressing with or without** a pressure bandage **CAN** be used to control compressible junctional hemorrhage

#### Remember:

- **DO NOT** pack hemostatic dressing into the abdomen or chest
- A BFAK contains one hemostatic dressing and one dry sterile gauze



- For compressible (external) hemorrhage not amenable to limb TQ (places where a tourniquet cannot be effectively applied) or for bleeding from wounds not requiring a TQ, use a UN recommended hemostatic dressing

## MASSIVE HEMORRHAGE CONTROL

### WOUND PACKING

- Identify the **exact source** of bleeding and **APPLY direct pressure** as a **temporary** measure **UNTIL** gauze is placed
- Pack the wound, **maintaining CONSTANT** direct pressure at the source of bleeding within **90 SECONDS** for it to be effective
- **HOLD** direct pressure on the gauze over the wound for at least **3 MINUTES** (**this is necessary**, even with the active ingredient in hemostatic dressing)
- When packing a large wound, more than one hemostatic dressing and/or **additional** gauze may be **needed**
- Carefully **observe** to determine if bleeding has been **controlled**



- Once you are sure the bleeding has **stopped**, apply a pressure bandage

## MASSIVE HEMORRHAGE CONTROL

# WOUND PACKING FOR FAILED CONTROL



- If packed with hemostatic dressing, **remove** before packing material and **repack** with a new hemostatic dressing, as available
- It may be a **fresh** dressing of the **same** or **different type**
- Alternatively, additional **hemostatic** or **nonhemostatic dressing** **CAN** be applied on top of the first gauze
- If hemostatic dressing is **NOT** readily available, use dry sterile gauze or some other materials to pack the wound

## MASSIVE HEMORRHAGE CONTROL

# PRESSURE BANDAGES



- **ALL** dressings for **significant** bleeding **should be secured** with pressure bandages
- Place the bandage pad **directly** on the dressing, **continuing to apply direct pressure**
- Wrap the pressure/elastic bandage **tightly**, focusing pressure directly over the wound
- **SECURE** the hooking **ends** of the Velcro or closure bar onto the last wrap of the bandage



## MASSIVE HEMORRHAGE CONTROL

# PRESSURE BANDAGE ASSESSMENT



### Key Points:

- Check for **circulation** **BELOW** the pressure bandage by **feeling for 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

## MASSIVE HEMORRHAGE CONTROL

# PRESSURE BANDAGES

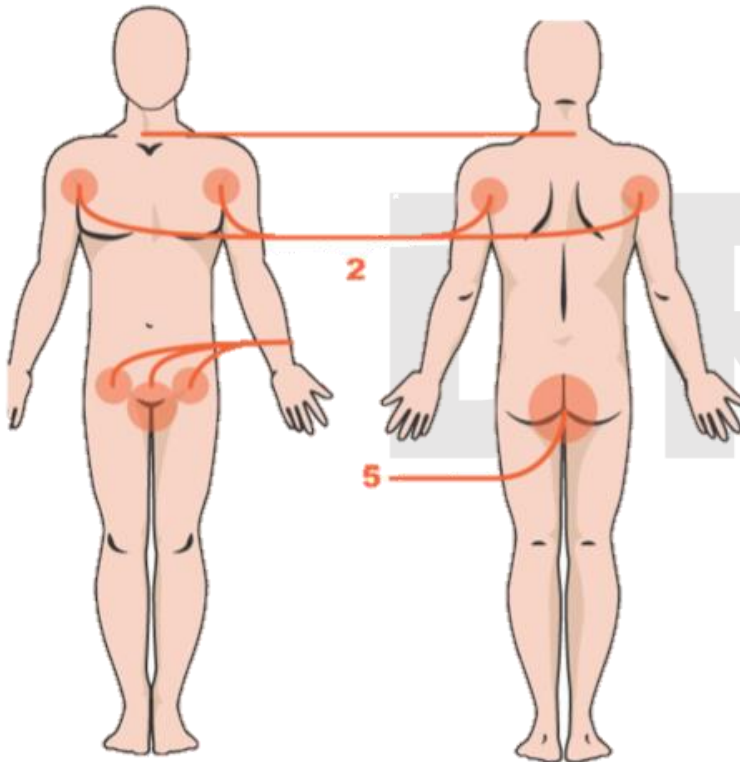
**PRESSURE BANDAGE**

Video can be found on [DeployedMedicine.com](http://DeployedMedicine.com)



## JUNCTIONAL HEMORRHAGE

# JUNCTIONAL ANATOMY



- Junctional areas are located at the **junction of the extremities** and **neck** with the torso
- Junctional hemorrhage can also occur on the extremities if the **injury is TOO CLOSE to the torso** for a tourniquet to be applied
- Blood vessels at **junctional areas are LARGER** than in the limbs but **can still be COMPRESSED** with direct pressure



## JUNCTIONAL HEMORRHAGE

# NECK JUNCTIONAL HEMORRHAGE CONTROL



- **Pack** the wound
- **Apply pressure** for **3 MINUTES**
- **Secure** with 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



MASSIVE HEMORRHAGE CONTROL

## NECK JUNCTIONAL HEMORRHAGE CONTROL

**NECK JUNCTIONAL  
HEMORRHAGE CONTROL**

Video can be found on [DeployedMedicine.com](https://DeployedMedicine.com)

## JUNCTIONAL HEMORRHAGE

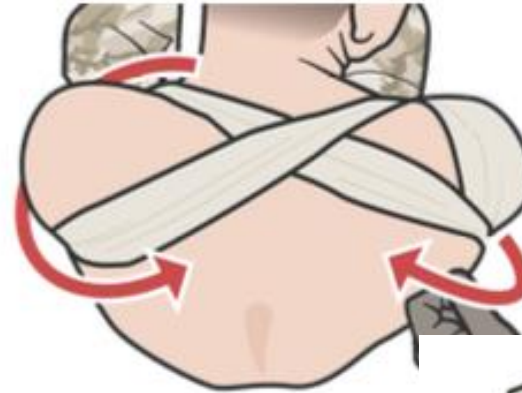
# AXILLARY JUNCTIONAL HEMORRHAGE CONTROL



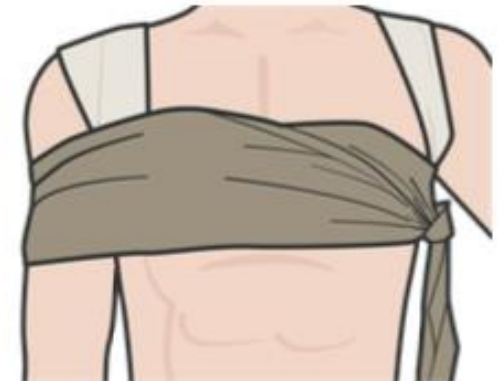
- **Expose** the wound



- **Pack** the wound



- **Secure** the dressing in place



- **Swath** the (injured side) upper arm to the side of the chest using a **cravat**



MASSIVE HEMORRHAGE CONTROL

# AXILLARY JUNCTIONAL HEMORRHAGE CONTROL

**AXILLARY JUNCTIONAL  
HEMORRHAGE CONTROL**

Video can be found on [DeployedMedicine.com](https://DeployedMedicine.com)

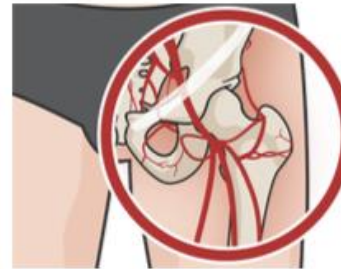
## JUNCTIONAL HEMORRHAGE

# JUNCTIONAL HEMORRHAGE CONTROL WITH A PRESSURE DELIVERY DEVICE (PDD)

- A PDD is made by using such materials as a **shoe/boot, full water bottle, or canteen**



- For groin injuries packed with hemostatic dressing, use an improvised junctional PDD to **SECURE** the **gauze**



- The PDD is placed in the inguinal gutter while **CONTINUOUSLY MAINTAINING** pressure to the gauze
- The PDD is then **secured** with a tourniquet and **tightened** to add **ADDITIONAL** pressure
- You may need to put **two TQs TOGETHER** when improvising a PDD

MASSIVE HEMORRHAGE CONTROL

**INGUINAL IMPROVISED JUNCTIONAL WITH PDD**

**PRESSURE DELIVERY DEVICE  
(for Junctional Hemorrhage)**

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)

## MASSIVE HEMORRHAGE CONTROL

# SKILL STATION

### TFC Hemorrhage Control (Skills)

- Wound Packing with hemostatic dressing and Pressure Bandage
- Neck Junctional Hemorrhage Control
- Axillary (Armpit) Junctional Hemorrhage Control
- Inguinal (Groin) Hemorrhage Control with Improvised Junctional Pressure Delivery Device (PDD)



## MASSIVE HEMORRHAGE CONTROL SUMMARY

### Pressure bandages over areas like the:

- Base of the neck
- Axilla
- Groin
- Buttocks
- Perineum
- Junctional areas have **specific** application techniques that **MAXIMIZE** the amount of pressure they exert on the gauze
- **Recheck** the dressing **FREQUENTLY**, especially while transporting the casualty to **next level of care**
- **WATCH FOR RE-BLEEDING**

## CHECK ON LEARNING

- What is the proper distance a deliberate tourniquet should be placed from the bleeding site in TFC?
- What is the difference between the need for high & tight/hasty tourniquets in CUF as opposed to deliberately placed tourniquets in TFC?
- How long should direct pressure be applied on packed hemostatic dressings?
- Why is it important to check the pulse after applying a pressure bandage?
- What additional intervention beyond packing with hemostatic dressing and wrapping with a pressure bandage is necessary to stop the bleeding from a groin wound?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## MODULE 07: AIRWAY MANAGEMENT

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**TO8** Given a combat peacekeeping or non-combat peacekeeping scenario, perform airway management during Tactical Field Care in accordance with TFMA Guidelines

**EO45** Identify signs of an airway obstruction

**EO46** Demonstrate opening the airway with the head-tilt chin-lift or jaw-thrust maneuver

**EO47** Demonstrate the placement of a casualty in the recovery position in Tactical Field Care

**EO48** Demonstrate the insertion of a nasopharyngeal airway (NPA) into a casualty in Tactical Field Care

**EO49** Describe the technique for ventilating a casualty with a bag valve mask (BVM) in Tactical Field Care

## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**MASSIVE BLEEDING** #1 Priority

➤ **AIRWAY**

**R**ESPIRATION

**C**IRCULATION

**H**YPOTHERMIA / HEAD INJURIES

### *AFTER* LIFE-THREATENING

**P**AIN

**A**NTIBIOTICS

**W**OUNDS

**S**PLINTING

## AIRWAY

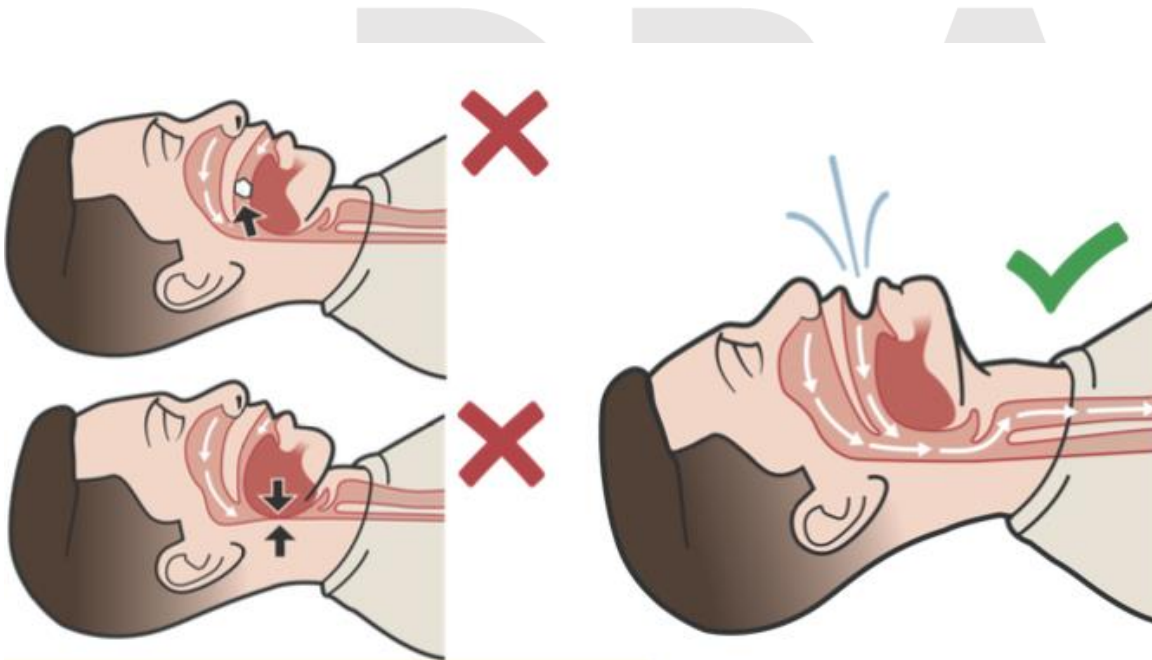
# AIRWAY MANAGEMENT

- Airway obstruction on the battlefield is often due to maxillofacial trauma
- If the casualty is breathing on their own but **unconscious** or **semi-conscious**, and there is no airway obstruction, further airway management is achieved through a **Nasopharyngeal Airway (NPA)**
- **Unconscious** casualties can also lose their airway as the muscles of their tongue may have relaxed, causing the tongue to block the airway by sliding to the back of the mouth and covering the opening to the windpipe



## IDENTIFYING AN OBSTRUCTED AIRWAY

# IDENTIFYING OBSTRUCTED AIRWAY



**IMPORTANT!** Remove any visible objects, obstructing the airway, but do not perform a blind finger sweep

### SIGNS AND SYMPTOMS

#### AIRWAY MAY BE BLOCKED:

- Casualty is in distress and indicates they can't breathe properly
- Casualty is making snoring or gurgling sounds
- Visible blood or foreign objects are present in the airway
- Maxillofacial trauma (severe trauma to the face) is observed

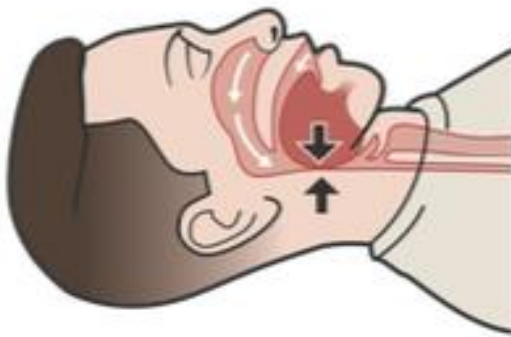
# MARCH



## OPENING THE AIRWAY

# IN A CASUALTY WITHOUT A FOREIGN BODY AIRWAY OBSTRUCTION, YOU CAN PERFORM THE FOLLOWING MANEUVERS:

**Unconscious** casualty's tongue may have **relaxed**, causing the tongue to **BLOCK** the airway by sliding to the back of the mouth and **covering the opening to the windpipe**



**HEAD-TILT CHIN-LIFT**



**JAW-THRUST**



If you suspect that the casualty has suffered a neck or spinal injury, use the jaw-thrust method

**M A R C H**



## AIRWAY MANAGEMENT

# HEAD-TILT/CHIN-LIFT AND JAW-THRUST MANEUVER

## HEAD-TILT/CHIN-LIFT AND JAW-THRUST MANEUVER

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)



## SKILL STATION

### Airway (Skills)

- Head-Tilt/Chin-Lift
- Jaw-Thrust Maneuver

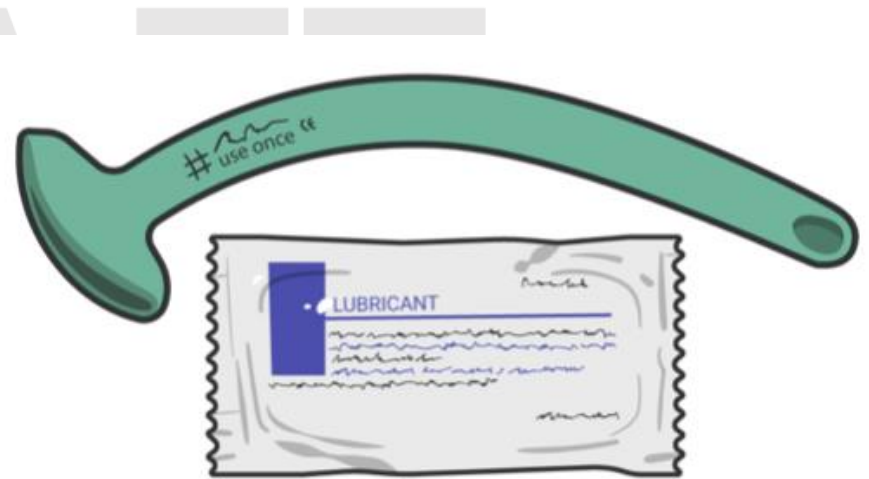
DRAFT

## OPENING THE AIRWAY

# MANAGING THE AIRWAY

**IF** the casualty is breathing on their own but **unconscious** or **semi-conscious** **AND** there is no airway obstruction, further airway management is best achieved with a **nasopharyngeal airway (NPA)**

An **NPA** can be used on a **conscious** or **unconscious** casualty to help open/maintain an open airway



**DO NOT** attempt to insert an NPA if there is clear fluid coming from the nose or ears. This may be cerebrospinal fluid (CSF) and may be an indication of possible skull fracture.

# MARCH



## AIRWAY MANAGEMENT

# NPA HOW-TO VIDEO

**NASOPHARYNGEAL AIRWAY**

Video can be found on [DeployedMedicine.com](http://DeployedMedicine.com)

## MAINTAINING THE AIRWAY

# CASUALTY POSITIONING

- If a casualty **can breathe on their own**, let them assume the best position that allows them to breathe, including sitting up
- If a casualty **can breathe on their own in a position of choice, DO NOT** force them into a position or perform airway procedures that causes them difficulties in breathing



## MANAGING THE AIRWAY

# MAINTAINING THE AIRWAY/RECOVERY POSITION



Casualties with **severe facial injuries** can often protect their own airways by sitting up and leaning forward



Assist a **conscious** casualty by helping them assume **any position** that **ALLOWS THEM TO BREATHE EASILY**, including sitting up

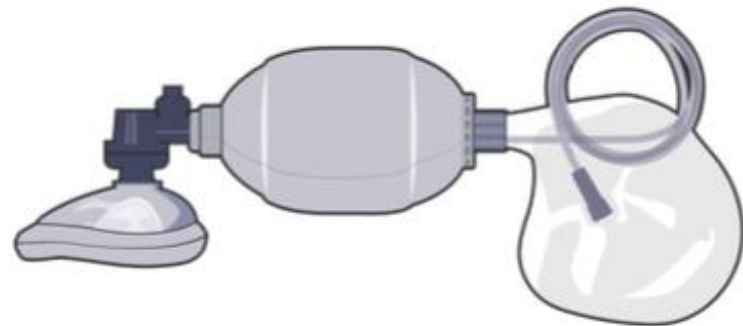


For an **unconscious** casualty not in shock, place them into the **RECOVERY POSITION**

# MARCH

## CASUALTY UNABLE TO BREATHE ON THEIR OWN

- **Medical personnel** may ask you to assist them in ventilating a patient using a **bag valve mask (BVM)**
- If respirations are noted to be reduced, provide ventilator support with BVM ventilations
- A BVM is a device that can assist a casualty with breathing (ventilation) if they are **NOT** breathing adequately on their own





## MANAGING THE AIRWAY

# BAG VALVE MASK (BVM)

## ONE & TWO-PERSON BAG VALVE MASK (BVM) VIDEO

Video can be found on [DeployedMedicine.com](http://DeployedMedicine.com)



- Ventilations can be performed alone or with two people working together
- The mask is **sealed** over the casualty's mouth so that air **doesn't** escape
- Squeeze **firmly** for **1-2 seconds** and **5-6 seconds** apart

# M A R C H

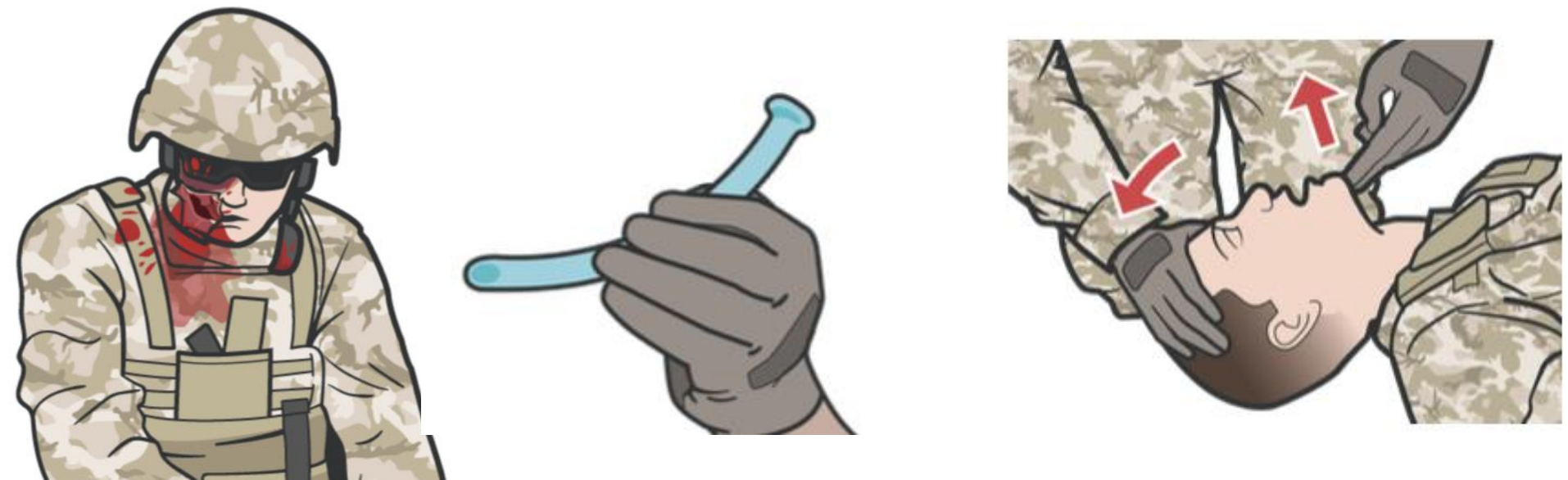
## SKILL STATION

### Airway (Skills)

- Recovery Position
- Nasopharyngeal Airway (NPA)
- One-Person Bag Valve Mask (BVM)/Two-Person BVM

## SUMMARY

- We identified
- We opened
- We maintained and managed
- For casualties in which airway positioning and/or nasopharyngeal airways **DO NOT** successfully maintain an open airway, **notify medical personnel IMMEDIATELY**





## CHECK ON LEARNING

- What is the best position for a conscious casualty who is breathing on their own?
- Why are casualties placed in the recovery position?
- What are the two methods that can be used to open an airway?
- How does an NPA provide an open (patent) airway?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## MODULE 08: RESPIRATION ASSESSMENT AND MANAGEMENT

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**TO9** Given a combat peacekeeping or non-combat peacekeeping scenario, perform assessment and management of respiration and chest trauma during Tactical Field Care in accordance with TFMA Guidelines

- EO50** Identify the signs and symptoms of respiratory distress
- EO51** Identify the signs and symptoms of a life-threatening chest injury
- EO52** Identify the signs and symptoms of open pneumothorax (sucking chest wound) in Tactical Field Care
- EO53** Identify the importance and implications of vented and non-vented chest seals
- EO54** Demonstrate the application of a chest seal to an open chest wound
- EO55** Identify the signs, symptoms, and initial treatment of tension pneumothorax in Tactical Field Care
- EO56** Demonstrate a needle decompression of the chest at the second intercostal space in midclavicular line
- EO57** Demonstrate a needle decompression of the chest at the fifth intercostal space in the anterior axillary line
- EO58** Identify the signs of recurring or unsuccessful treatment of tension pneumothorax

## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**MASSIVE BLEEDING** #1 Priority

**AIRWAY**

**RESPIRATION**

**CIRCULATION**

**HYPOTHERMIA / HEAD INJURIES**

### *AFTER* LIFE-THREATENING

**PAIN**

**ANTIBIOTICS**

**WOUNDS**

**SPLINTING**





# RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

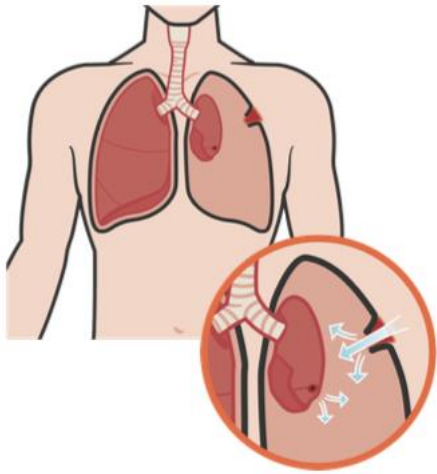
## RESPIRATION OVERVIEW

### **RESPIRATION ASSESSMENT AND MANAGEMENT IN TACTICAL FIELD CARE**

Video can be found on [DeployedMedicine.com](https://DeployedMedicine.com)

## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

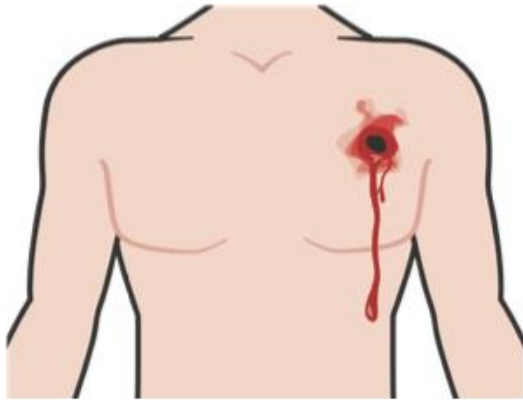
# LIFE-THREATENING CHEST INJURY



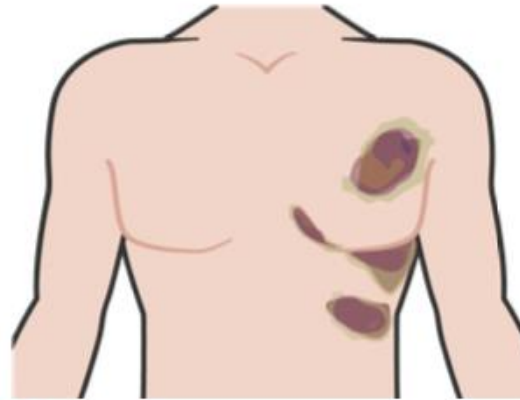
- Respiratory distress means **DIFFICULTY BREATHING** (rapid or abnormally slow breathing), in other words, it is difficult for the casualty to **get air in or out**
- The pleural space between the lungs and chest wall naturally has negative pressure, which helps the lungs to collapse (exhale) and expand (inhale)
- With either a **BLUNT** or **PENETRATING INJURY** to the chest wall or lungs, air may counteract the lung's natural tendency to expand and collapse
- This is due to positive pressure replacing negative pressure
- It results in air being trapped in the pleural space, putting pressure on the affected lung
- This forces the lung to collapse and reduces the ability to get oxygen to the body

## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

### LIFE-THREATENING CHEST INJURY



**Gunshot or shrapnel wound** to the chest  
(penetrating trauma)



FT

- **Blunt force** trauma (force from an IED explosion, high-impact vehicle accident (chest hitting steering wheel), etc.
- **Bruising, contusions** (swelling around the chest, back or rib cage), **crepitus** that is felt or heard (crackling, popping, grating)
- **ANY** deformities of the chest

#### REMEMBER:

- These injuries can lead to a tension pneumothorax
- This is the **second leading cause** of preventable death

M A R C H

## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

### IDENTIFYING TENSION PNEUMOTHORAX



**Remember!** Airway and Respiration are NOT addressed in CUF and must be addressed in TFC

#### SIGNS AND SYMPTOMS OF **PROGRESSIVE** RESPIRATORY DISTRESS:

- **Progressive** difficulty breathing (labored and rapid breathing worsening overtime)
- **Shortness** of breath
- Confusion/lightheaded and/or agitation due to lack of oxygen
- Bluish discoloration around mouth and lips
- Rapid pulse
- Distended jugular veins

# MARCH

## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

# SIGNS AND SYMPTOMS OF OPEN PNEUMOTHORAX OR SUCKING CHEST WOUND IN TFC



Open Pneumothorax

A casualty with an open chest wound will exhibit **ONE OR MORE** of the following signs and symptoms:

- A “**sucking**” or “**hissing**” sound when the casualty **inhales**
- Difficulty breathing
- A **puncture wound** of the chest
- **Froth** or **bubbles** around the injury
- Coughing up blood
- Blood-tinged sputum (spit)

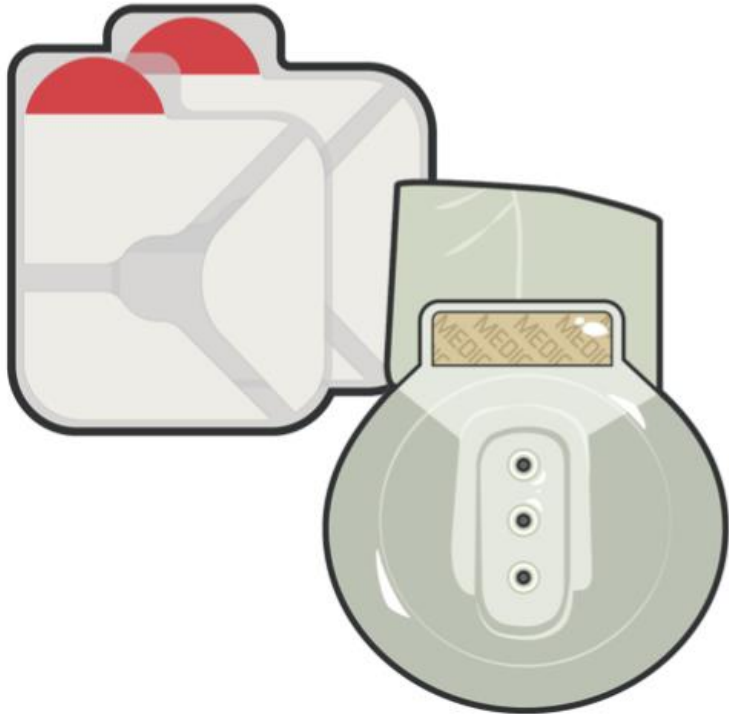
### REMEMBER:

- If you are **not sure** if the wound has **penetrated** the chest wall completely, **treat the wound** as though it were an **open chest wound**
- If **multiple** wounds are found, treat them **in the order in which you find them**

# M A R C H

## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

### VENTED CHEST SEALS



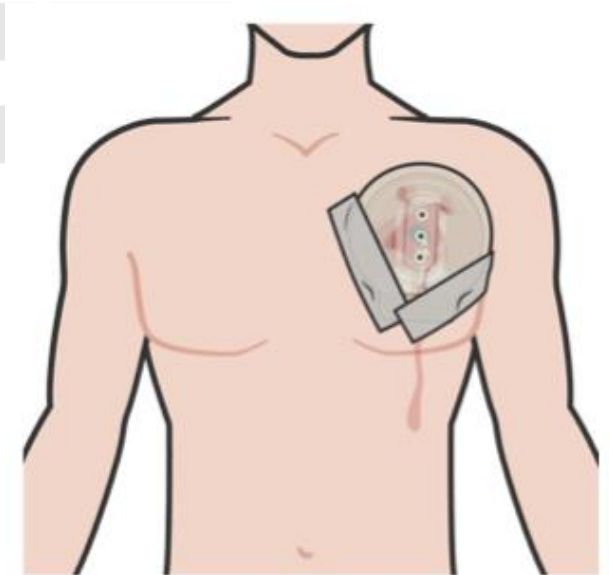
- Vented chest seals are for **treating penetrating wounds** to the chest
- Vented chest seals allow air to **escape** out of the chest while non-vented chest seals **do not**
- The injured lung will remain partially collapsed, **but the mechanics of respiration will be better**

## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

# VENTED **AND** NONVENTED CHEST SEALS

Recommended treatment for **open** or **sucking** chest wounds is **prompt application** of a vented chest seal:

- If vented chest seal **is NOT** available, a nonvented chest seal should be used
- Vented chest seals allow air to **escape** out of the chest while nonvented chest seals **do not**
- When the casualty inhales, the plastic should be sucked against the wound, **preventing the entry of air**
- When the casualty exhales, trapped air should be able to escape from the wound and out the valve



**MONITOR** the casualty **closely** and if their condition MA RR C H **worsens**, you should **suspect a tension pneumothorax**.

**Treat this by burping or temporarily removing the dressing.**

# M A **R** C H



## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

# POSITION AFTER OCCLUSIVE DRESSING TREATMENT

- If the casualty is unconscious, place the casualty in the recovery position
- If the casualty is conscious, allow the casualty to adopt the sitting position if breathing is more comfortable







## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

# CHEST SEAL

**CHEST SEAL**

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)



## SKILL STATION

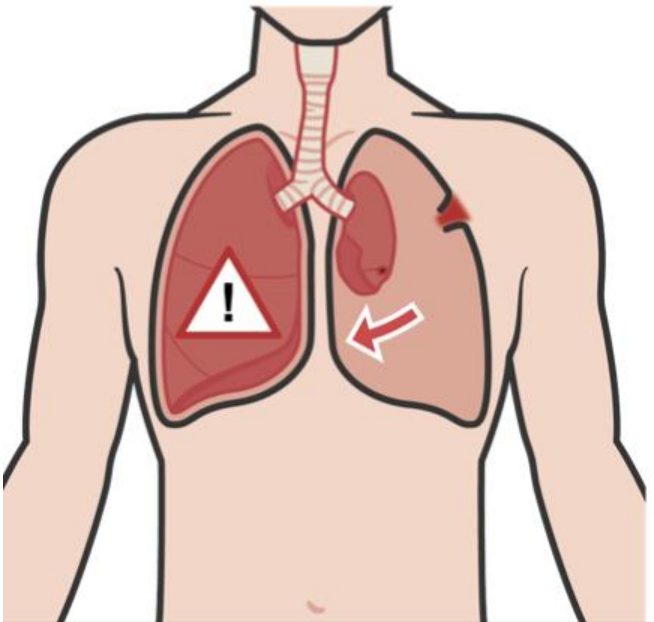
Respiration (Skill)

- Chest Seal

DRAFT

## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

# TENSION PNEUMOTHORAX



- A tension pneumothorax is the **second-leading cause** of preventable deaths on the battlefield
- As a tension pneumothorax develops, air enters the chest cavity **through the wound WITH EVERY BREATH**
- Injured lung tissue acts as a **one-way valve**, **TRAPPING more and more air between the lung and the chest wall**

**PRESSURE BUILDS UP AND COMPRESSES  
BOTH LUNGS AND THE HEART**

**M A R C H**

## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

# CONSIDER TENSION PNEUMOTHORAX IN TACTICAL FIELD CARE



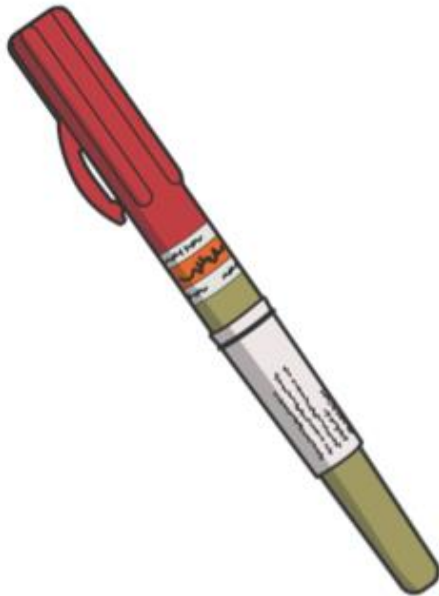
Caused by **SIGNIFICANT TORSO TRAUMA** or primary blast injury followed by **severe/progressive respiratory distress** (a respiratory rate **>20 breaths per minute**)

- The recommended treatment of suspected tension pneumothorax is **Needle Decompression of the Chest (NDC)**

# M A R C H

## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

# UNSUCCESSFUL TREATMENT OR RECURRENCE OF TENSION PNEUMOTHORAX



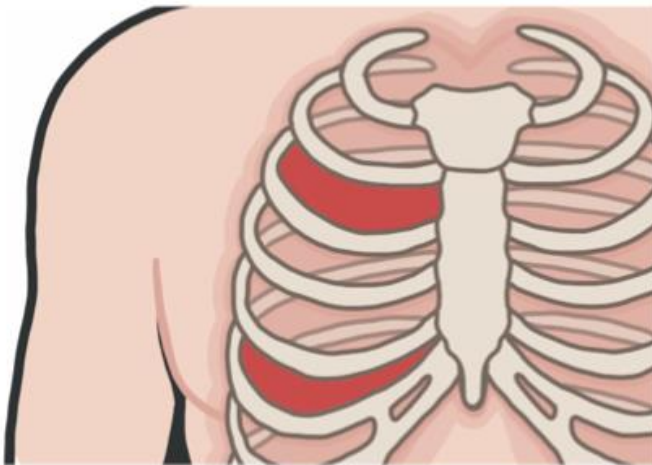
- Burp the chest seal if one is in place
- If **initial** NDC **does not** result in improvement, a second NDC should be attempted at the **alternate recommended site**
- If tension pneumothorax initially responds to NDC, but symptoms later **recur**, then **repeat NDC at the same site right beside the original NDC**
- If **no improvement** is noted with the second NDC, **proceed with** circulation assessment and treatment following the **MARCH protocol**

**DO NOT** put NDC through a chest seal!  
Use alternate site instead

# MARCH

## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

### NDC **SITE SELECTION**



- Site selection is based on the **mechanism of injury AND physical findings**
- Use either the **second (A)** or **fifth (B)** intercostal space (**either is preferred**)
- If the needle is used at the second intercostal space, **ensure** the site selection is **OUTSIDE** the nipple line

**M A R C H**

## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

### POSITION AFTER NDC TREATMENT

- If the casualty is unconscious, place the casualty in the recovery position
- If the casualty is conscious, allow the casualty to adopt the sitting position if breathing is more comfortable





## RESPIRATION ASSESSMENT AND MANAGEMENT IN TFC

# NEEDLE DECOMPRESSION OF THE CHEST

### **NEEDLE DECOMPRESSION OF THE CHEST**

Video can be found on [DeployedMedicine.com](https://DeployedMedicine.com)



## SKILL STATION

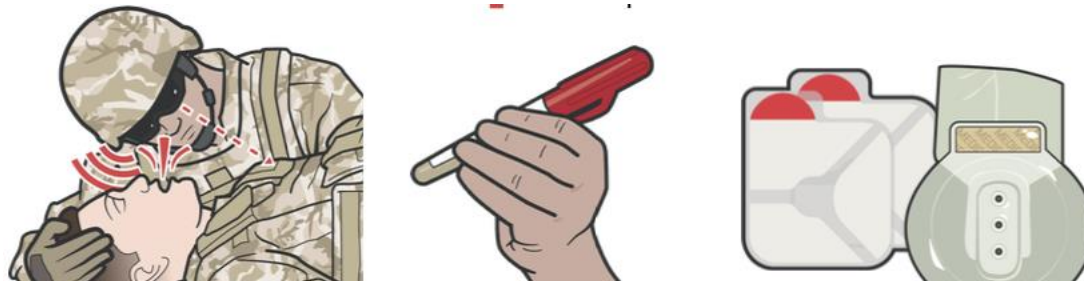
### Respiration (Skill)

- Needle Decompression of Chest (NDC)

DRAFT

## SUMMARY

- We **identified** the **signs and symptoms** of an open pneumothorax
- We **discussed** the **treatment** options for an open pneumothorax
- We **identified** the **signs and symptoms** of a tension pneumothorax
- We **discussed** the treatment for a tension pneumothorax
- **Both types** of chest injuries (sucking chest wounds and tension pneumothorax) **WILL REQUIRE** advanced evaluation by **medical personnel** and **evacuation**
- Tension pneumothorax is a **PREVENTABLE** cause of death



## CHECK ON LEARNING

- What is a tension pneumothorax?
- How should you treat an open chest wound?
- What should you do if you suspect a casualty has a tension pneumothorax?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## MODULE 09: CIRCULATION / HEMORRHAGE CONTROL

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**T10** Given a combat peacekeeping or non-combat peacekeeping scenario, perform haemorrhage control during Tactical Field Care in accordance with TFMA Guidelines

**EO59** Identify the principles of wound packing and applying pressure bandages

**EO60** Demonstrate wound packing and applying a pressure bandage

**EO61** Identify progressive strategies, indications, and limitations of controlling external hemorrhage in Tactical Field Care

**EO62** Identify the signs, symptoms, and considerations of a pelvic fracture

## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

**NOTE:** This is covered in more advanced TFMA training!



YOU ARE HERE

## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**MASSIVE BLEEDING** #1 Priority

**AIRWAY**

**RESPIRATION**

**➤ CIRCULATION**

**HYPOTHERMIA / HEAD INJURIES**

### *AFTER* LIFE-THREATENING

**PAIN**

**ANTIBIOTICS**

**WOUNDS**

**SPLINTING**





## HEMORRHAGE CONTROL IN TFC

# **HEMORRHAGE CONTROL IN TACTICAL FIELD CARE**

Video can be found on [DeployedMedicine.com](https://DeployedMedicine.com)

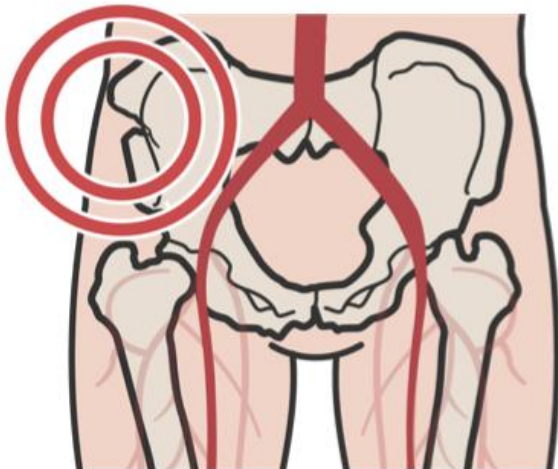
## HEMORRHAGE CONTROL

# PELVIC FRACTURES

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:

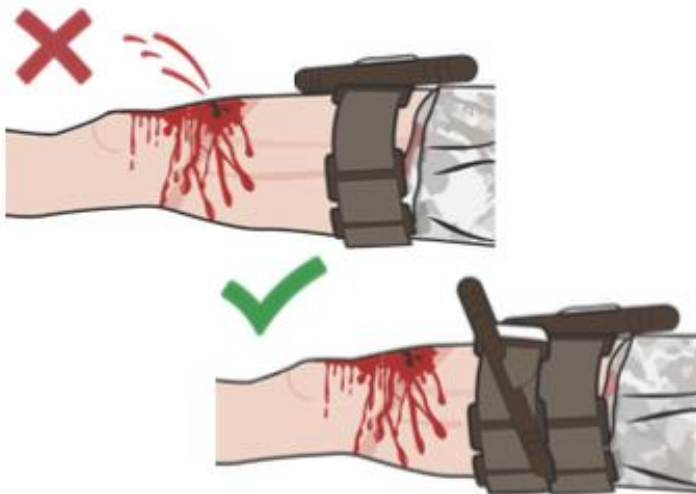
- **Pelvic pain**
- Major lower limb **amputation** **OR** lower **near amputations**
- Deformities, penetrating injuries, bruising near the pelvis
- **Pelvic instability** or **crepitus** (crinkly or grating feeling or sound under the skin)
- **Unconsciousness** or **shock**



If a pelvic fracture is **suspected**, the casualty **WILL REQUIRE** advanced evaluation by **medical personnel**

## HEMORRHAGE CONTROL REASSESSMENT

- Reassess all **PREVIOUS** and **CURRENT** hemostatic dressings applied and ensure they are tight and effective
- If **ineffective**, apply a **second TQ side-by-side** with the first
- Reassess all **PREVIOUS** and **CURRENT** hemostatic dressings applied for **effectiveness**
- If you placed a TQ above a casualty's elbow, for instance, you should expect to **find no pulse** at the wrist below if the TQ was properly applied



## HEMORRHAGE CONTROL STRATEGIES AND LIMITATIONS

### EARLY CONTROL OF SEVERE HEMORRHAGE IS CRITICAL

- TFMA recommended hemostatic dressings are to be applied **directly to the skin** in **TFC 2-3 inches above the bleeding site**
- Casualty's hemorrhage control interventions **must be FREQUENTLY REASSESSED** to ensure continued hemorrhage control



**DO NOT EVER APPLY IT  
AND FORGET IT!**



## HEMORRHAGE CONTROL

# WOUND PACKING AND PRESSURE DRESSING



- Identify the **exact source** of bleeding
- **Pack** the wound



Apply direct pressure for  
**3 MINUTES**



- **Secure** the 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

## HEMORRHAGE CONTROL WOUND PACKING

**KEEP  
PRESSURE**



- Identify the **exact source** of bleeding and **APPLY direct pressure** as a **temporary** measure **UNTIL** gauze is placed
- Pack the wound **maintaining CONSTANT** direct pressure at the source of bleeding within **90 SECONDS** to be effective
- **HOLD** direct pressure on the gauze over the wound for at least **3 MINUTES** (**this is necessary**, even with the active ingredient in hemostatic dressings)
- When packing a large wound, more than one hemostatic gauze and/or **additional** gauze may be **needed**
- Carefully **observe** to determine if bleeding has been **controlled**

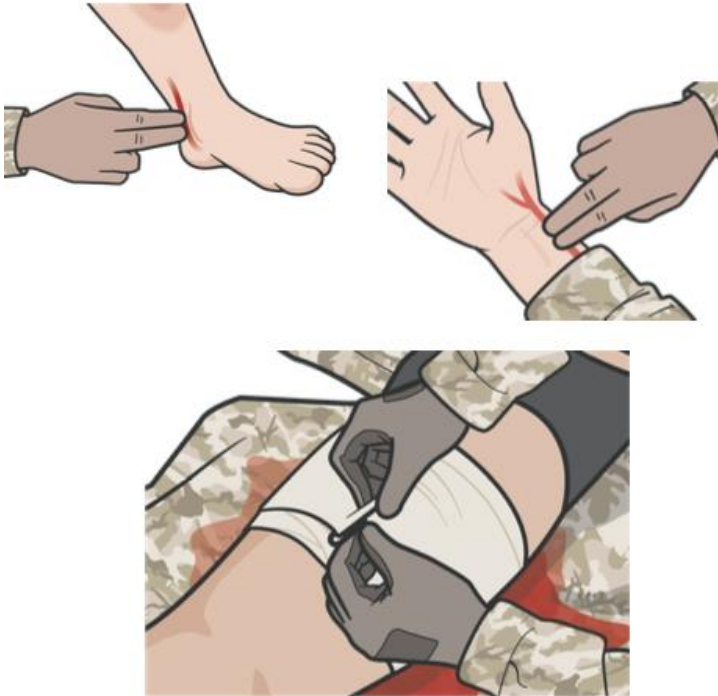
Once you are sure the bleeding has **stopped**, apply a pressure bandage

**3 MINUTES**



## HEMORRHAGE CONTROL

# PRESSURE BANDAGE REASSESSMENT



### Key Points:

- Check for **circulation BELOW** the pressure bandage by **feeling for 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**

## HEMORRHAGE CONTROL

### IF THE PRESSURE BANDAGE IS INEFFECTIVE



- If the pressure bandage or hemostatic dressing is **ineffective**, **APPLY** a hemostatic dressing **2-3 inches above** the bleeding site
- If the pressure bandage is **ineffective AND/OR blood soaked**, **REPLACE** pressure dressing with **hemostatic dressing**
- Pack the wound, **maintaining CONSTANT** direct pressure at the source of bleeding within **90 SECONDS** to be effective





## PRESSURE BANDAGE

### PRESSURE BANDAGE

Video can be found on [DeployedMedicine.com](http://DeployedMedicine.com)



## SKILL STATION

### Circulation/Hemorrhage Control (Skills)

- Wound Packing with Hemostatic Dressing and Pressure Bandage

DRAFT

## SUMMARY

- If not already done, **clearly mark ALL TQs** with the **time** of TQ application and document that on the **Casualty Card**
- Check for radial pulse
- Assess for shock



## CHECK ON LEARNING

- During Circulation in the MARCH PAWS sequence, what interventions should be reassessed?
- What are the signs and symptoms of a pelvic fracture?

DRAFT



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## MODULE 10: SHOCK RECOGNITION

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

### **T11** Describe shock assessment in Tactical Field Care in accordance with TFMA Guidelines

**EO63** Identify the signs, symptoms, and management steps of shock in a trauma casualty with life-threatening bleeding

**EO64** Identify the importance of level of consciousness and radial pulse as indicators of shock in Tactical Field Care

## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**MASSIVE BLEEDING** #1 Priority

**AIRWAY**

**RESPIRATION**

**➤ CIRCULATION**

**HYPOTHERMIA / HEAD INJURIES**

### *AFTER* LIFE-THREATENING

**PAIN**

**ANTIBIOTICS**

**WOUNDS**

**SPLINTING**





## SHOCK RECOGNITION

### SHOCK RECOGNITION

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)

## CIRCULATION/SHOCK

# SHOCK

- Shock is **inadequate blood flow to body tissues**. Inadequate blood volume inside the circulatory system results in inadequate oxygen delivery to the body's cells
- As cells cease to function, tissues cease to function, then organs cease to function, and eventually the **whole body will fail** and **DEATH** follows



### **IMPORTANT CONSIDERATIONS:**

Shock will lead to the casualty's death if not quickly recognized and treated

## CIRCULATION/SHOCK

# SHOCK

- Caused by a decrease in the amount of blood volume circulating in the casualty's blood circulatory system
- Shock can have many causes – low blood volume or hypovolemia (dehydration or blood loss), low blood pressure (massive infection), heart failure, or neurologic damage
- Usually caused by severe bleeding, but it can also be caused by severe burns (second- and third-degree burns on 20 percent or more of the body surface)
- On the battlefield, assume shock is from severe blood loss (also called hemorrhagic shock)

Hemorrhagic shock can result in the casualty's **death**



# M A R C H

## CIRCULATION/SHOCK

# GENERAL INDICATORS OF SHOCK

### SIGNS AND SYMPTOMS OF SHOCK INCLUDE:

- **Mental confusion**
- **Weak or absent radial pulse**
- Rapid breathing
- Nausea
- Sweaty, cool, clammy skin
- Excessive Thirst
- Pale/grey skin
- Previous severe bleeding



**M A R C H**

## CIRCULATION/SHOCK

# GENERAL INDICATORS OF SHOCK

### IMPORTANT Indicator:

- Mental confusion

### IMPORTANT Indicator:

- Weak or absent radial pulse

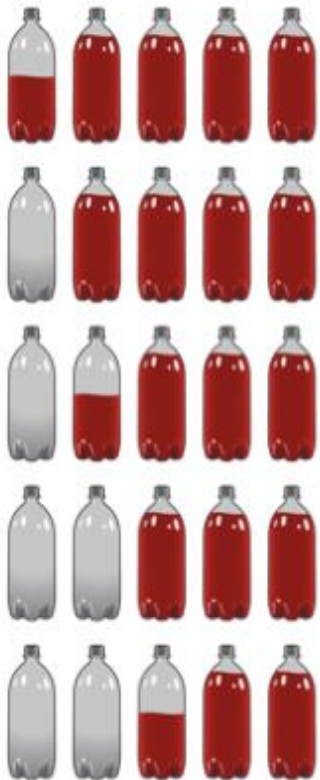


If **BOTH** indicators exist, the casualty has lost a **SIGNIFICANT** amount of blood

As previously stated, shock will lead to the casualty's **death** if not quickly recognized and treated

## CIRCULATION/SHOCK

# GENERAL INDICATORS OF SHOCK



Blood Volume	Blood Loss	Signs/Symptoms	Effectme
4 liter bottles full, 1 bottle 1/2 empty	500cc	Possible increased HR	Usually no effects
4 liter bottles full, 1 empty	1000cc	Radial pulse >100 Breathing probably normal	Unlikely to die from this amount of loss
3 1/2 bottles full, 1 1/2 empty	1500cc	Change in mental status Weak radial pulse >100 Increased respirations	Still unlikely to die
3 bottles full, 2 empty	2000cc	Confusion and lethargy Very weak radial pulse >120 High respiratory rate >35	Very possibly fatal if not managed
2 1/2 bottles full and 2 1/2 bottles empty	2500cc	Unconscious No radial pulse, carotid pulse, HR >140 Respirations > 35	Fatal without immediate and rapid interventions

M A R C H

## CIRCULATION/SHOCK

# PREVENT SHOCK BY CONTROLLING BLEEDING

*#1- Reassess to confirm all bleeding control measures are still effective*

*Ensure TQs and pressure dressings remain tight*

- *Check radial pulse*



- It is better to prevent shock with hemorrhage control than to treat it
- If shock is present, though, the most critical first step is to control the bleeding
- Internal bleeding from chest or abdominal trauma may not be controllable, and shock may develop later, so continuously assess the casualty
- Medical personnel will provide other treatments, but you can save them time if extremal bleeding is controlled

**DO NOT WAIT** for signs and symptoms of shock to occur

# M A R C H

## CIRCULATION/SHOCK

# ASSESS/MONITOR FOR **HEMORRHAGIC SHOCK**

- Assess for signs and symptoms of shock as soon as hemorrhage is controlled, the airway is open, and respirations have been managed
- The best indicators of shock are a decreased state of consciousness (if casualty has not suffered a head injury) and/or an abnormal, weak, absent radial pulse
- Assess for hemorrhagic shock (altered mental status in the absence of brain injury and/or weak or absent radial pulse)
- Reassess/monitor for changes in the level of consciousness by checking for alertness or responsiveness to verbal or physical stimulation



**M A R C H**



## SHOCK RECOGNITION

### REASSESS



#### Level of consciousness

Check casualty every 15 minutes for **AVPU**

**A**lertness - Knows who, where they are

**V**erbal - Orally responds to verbal commands

**P**ain - Level of pain felt when the sternum is briskly rubbed with the knuckle (if needed)

**U**nconscious - Unresponsive

**Decreasing** AVPU could indicate condition worsening

#### Breathing rate

Monitor respirations

- Thoracic trauma may indicate tension pneumothorax (needle decompression of the chest required)
- If a casualty becomes unconscious or their breathing rate drops below two respirations every 15 seconds, insert a nasopharyngeal airway

## CIRCULATION/SHOCK

# SHOCK MANAGEMENT



- Fluids by mouth are permissible if the casualty is conscious and can swallow
- Evacuate the casualty if medical help is not available
- Place casualty in recovery position

Reassess the casualty frequently  
for the onset of shock

## CIRCULATION/SHOCK

# HYPOTHERMIA MANAGEMENT

### REMEMBER:

**Keep** the casualty **warm** and prevent hypothermia. Even in **very hot environments**, a casualty in **hemorrhagic shock** (blood loss) is at **EXTREME** risk for hypothermia

- Place a poncho or blanket under the casualty to protect from the temperature or dampness of the ground
- Cover the casualty with a survival blanket or other available materials to keep them warm and dry



## SUMMARY

### IMPORTANT

#### Indicator:

- Mental confusion

### IMPORTANT

#### Indicator:

- Weak or absent radial pulse

- We **defined** shock
- We **identified** indicators of shock
- We discussed **prevention measures** for shock
- We discussed the **management** of shock
- We **introduced** hypothermia



## CHECK ON LEARNING

- What is shock?
- What are the best indicators of shock?
- What is the most important action to prevent hemorrhagic shock?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## **DRAFT**

### MODULE 11: HYPOTHERMIA PREVENTION

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant



You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**T12** Given a combat peacekeeping or non-combat peacekeeping scenario, perform hypothermia prevention measures on a trauma casualty during Tactical Field Care in accordance with TFMA Guidelines

**EO65** Identify the progressive strategies, indications, and limitations of hypothermia prevention of a trauma casualty in Tactical Field Care

**EO66** Demonstrate active external warming hypothermia prevention measures on a trauma casualty

**EO67** Identify passive hypothermia prevention measures on a trauma casualty



## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**MASSIVE BLEEDING** #1 Priority

**AIRWAY**

**RESPIRATION**

**CIRCULATION**

**➤ HYPOTHERMIA / HEAD INJURIES**

### *AFTER* LIFE-THREATENING

**PAIN**

**ANTIBIOTICS**

**WOUNDS**

**SPLINTING**

## HYPOTHERMIA PREVENTION

# HYPOTHERMIA



- Hypothermia is the decrease in body temperature
- Even a small decrease in body temperature can interfere with blood clotting and increase the risk of bleeding to death
- Casualties in shock are unable to generate body heat effectively
- Hypothermia is a problem for casualties with haemorrhagic shock, even with warm, ambient temperatures

### **IMPORTANT CONSIDERATIONS:**

A lower body temperature may not be an indicator of hypothermia; it may be due to exposure to a cold environment

## HYPOTHERMIA PREVENTION

# HYPOTHERMIA PREVENTION

- Minimize the casualty's exposure to the elements
- Keep protective gear on or with the casualty if feasible
- Replace wet clothing with dry, if possible



You can better **prevent** hypothermia by getting the casualty onto an insulated surface as soon as possible



## HYPOTHERMIA PREVENTION

# HYPOTHERMIA PREVENTION

**Get the casualty onto an insulated surface as soon as possible.**

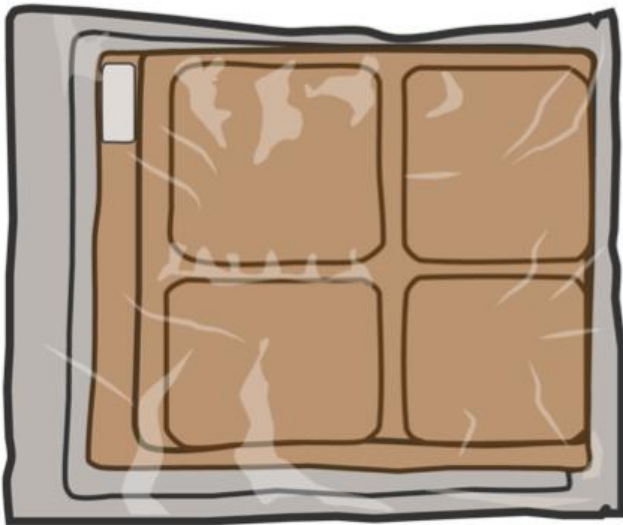


- Hypothermia is much easier to prevent than to treat
- Begin hypothermia prevention as soon as possible
- Decreased body temperature interferes with blood clotting and increases the risk of bleeding
- Blood loss can cause a significant drop in body temperature, even in hot weather

**M A R C H**

## HYPOTHERMIA

# ACTIVE HYPOTHERMIA PREVENTION



Your medical personnel will distribute the active hypothermia blankets based on unit mission and load

- Active hypothermia blankets are activated when their heating elements are exposed to air
- Active hypothermia blankets are applied to a casualty who cannot generate their own heat, but not directly on their skin because the activated blankets can cause burns

# M A R C H

## HYPOTHERMIA

# ACTIVE HYPOTHERMIA PREVENTION

Apply the active warming blanket from the active hypothermia blanket to the casualty's torso **(not directly on the skin)**, and cover the casualty with the passive hypothermia shell



### KEY POINTS:

- If an active hypothermia blanket is not available, a combination of the passive warming blanket and an active warming blanket may also be used
- Active hypothermia treatment uses heating sources to warm the casualty
- Oxygen levels at higher altitudes may not be enough to sustain the chemical reaction required to generate heat

# M A R C H



## HYPOTHERMIA

# PASSIVE HYPOTHERMIA PREVENTION



**Passive hypothermia materials provide heating by:**

- Keeping the casualty's body heat contained in the passive material
- Keeping the casualty off the ground

**M A R C H**



## HYPOTHERMIA

# PASSIVE HYPOTHERMIA PREVENTION

Place a poncho or blanket under the casualty to protect them from the temperature or dampness of the ground



- Passive hypothermia prevention does not reverse the hypothermic process
- If no rewarming equipment is available, then use dry blankets, poncho liners, sleeping bags, or anything that will retain heat and keep the casualty dry
- Keep the casualty off the ground

### KEY POINTS:

- Blood loss can cause a significant drop in body temperature, even in hot weather
- Wrap the entire blanket-like shell (or passive heating materials) completely around the casualty, including the head
- Do not cover the face

# MARCH





## HYPOTHERMIA PREVENTION VIDEO

### **HYPOTHERMIA PREVENTION**

Video can be found on [DeployedMedicine.com](http://DeployedMedicine.com)

## SKILL STATION

### Hypothermia (Skill)

- Active/passive external warming hypothermia prevention

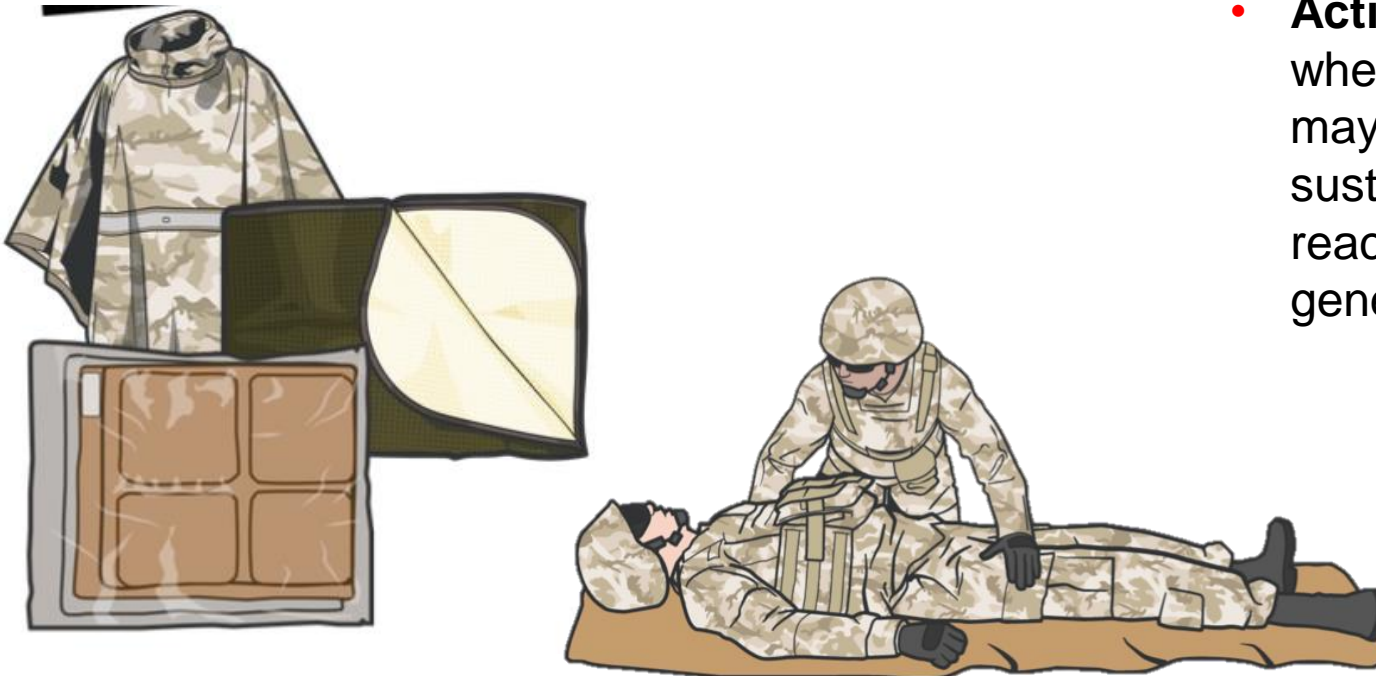
DRAFT

## SUMMARY

- We defined hypothermia
- We discussed active hypothermia management/prevention
- We discussed passive hypothermia management/prevention

### KEY POINTS:

- **Passive** hypothermia prevention **DOES NOT** reverse the hypothermic process
- **Active** hypothermia, when at high altitudes, may not be enough to sustain the chemical reaction required to generate heat



## CHECK ON LEARNING

- Why is it important to keep a trauma casualty warm even if it is a hot environment?
- What is the difference between active and passive hypothermia management?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## **MODULE 12: HEAD INJURIES**

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

### **T13** Identify a head injury in accordance with TFMA Guidelines

**EO68** Identify external forces that can cause a head injury

**EO69** Identify signs and symptoms of a head injury

**EO70** Identify the critical observations that should be reported to medical personnel for trauma casualties with a suspected head injury in accordance with the Military Acute Concussive Evaluation 2 (MACE 2).

## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

**NOTE:** This is covered in more advanced TFMA training!



YOU ARE HERE



## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**MASSIVE BLEEDING** #1 Priority

**AIRWAY**

**RESPIRATION**

**CIRCULATION**

**➤ HYPOTHERMIA / HEAD INJURIES**

### *AFTER* LIFE-THREATENING

**PAIN**

**ANTIBIOTICS**

**WOUNDS**

**SPLINTING**

## HEAD INJURIES

# POTENTIAL MECHANISMS OF HEAD INJURY

Head injury is trauma to the **scalp, skull, and/or brain**

- Involvement in a vehicle **blast event, collision, or rollover**
- Presence within **50 METERS** of a blast (**inside or outside**)
- A direct blow to the head or witnessed loss of consciousness
- Exposure to **more than one blast event** (the Service member's commander will direct a **medical evaluation**)



**OTHER EXTERNAL FORCES MAY ALSO LEAD TO HEAD INJURIES**

## HEAD INJURIES

# SIGNS AND SYMPTOMS OF HEAD INJURY

### IED Checklist

<b>Injury</b>	Physical damage to the body or body part of a Service member?	(Yes/No)
<b>Evaluation</b>	<b>H</b> – Headaches and/or vomiting?	(Yes/No)
	<b>E</b> – Ear ringing?	(Yes/No)
	<b>A</b> – Amnesia, altered consciousness, and/or loss of consciousness?	(Yes/No)
	<b>D</b> – Double vision and/or dizziness?	(Yes/No)
	<b>S</b> – Something feels wrong or is not right?	(Yes/No)
<b>Distance</b>	Was the Service member within 50 meters of the blast? Record the distance from the blast.	(Yes/No) Not Applicable

## HEAD INJURIES

# SIGNS AND SYMPTOMS REQUIRING MACE 2\*

## EVALUATION BY MEDICAL PERSONNEL

Evaluations are **most effective** when done **as soon as possible** after the injury. **Traumatic brain injury (TBI)** is likely if the casualty shows signs of **ANY** of the following:

- Deteriorating level of consciousness
- Double vision
- Increased restlessness; combative or agitated behavior
- Repeat vomiting
- Results from a structural brain injury detection device (if available)
- Seizures
- Weakness or tingling in arms or legs
- Severe or worsening headache



**MACE 2**  
Military Acute Concussion Evaluation

Use MACE 2 as close to time of injury as possible.

Service Member Name: \_\_\_\_\_  
DoD/ED/PUSSN: \_\_\_\_\_ Branch of Service & Unit: \_\_\_\_\_  
Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_  
Examiner: \_\_\_\_\_  
Date of Evaluation: \_\_\_\_\_ Time of Evaluation: \_\_\_\_\_

**Purpose:** MACE 2 is a multimodal tool that assists providers in the assessment and diagnosis of concussion. The scoring, coding and steps to take after completion are found at the end of the MACE 2.

**Timing:** MACE 2 is most effective when used as close to the time of injury as possible. The MACE 2 may be repeated to evaluate recovery.

**RED FLAGS**

Evaluate for red flags in patients with Glasgow Coma Scale (GCS) 13-15.

→ Deteriorating level of consciousness	→ Results from a structural brain injury detection device (if available)
→ Double vision	→ Seizures
→ Increased restlessness, combative or agitated behavior	→ Weakness or tingling in arms or legs
→ Repeat vomiting	→ Severe or worsening headache

Defer MACE 2 if any red flags are present. Immediately consult higher level of care and consider urgent evacuation according to evacuation precedence/Tactical Combat Casualty Care (TCCC).

→ **Negative for all red flags.**  
Continue MACE 2, and observe for red flags throughout evaluation.

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## SUMMARY

- We **defined** head injury
- We discussed **mechanisms of injury**
- We discussed **signs and symptoms**
- We identified **critical observations to report to higher medical personnel**



## CHECK ON LEARNING

- What external forces can cause a head injury?
- What are the critical observations that should be reported to medical personnel for trauma casualties with a suspected head injury, in accordance with MACE 2?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## **MODULE 13: EYE INJURIES**

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor



## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**T14** Given a combat peacekeeping or non-combat peacekeeping scenario, perform assessment and initial treatment of penetrating eye trauma during Tactical Field Care in accordance with TFMA Guidelines

**E071** Identify basic care of an eye injury in accordance with TFMA Guidelines

**E072** Demonstrate the application of a rigid eye shield to a trauma casualty in Tactical Field Care

## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

**NOTE:** This is covered in more advanced TFMA training!



YOU ARE HERE

## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**MASSIVE BLEEDING** #1 Priority

**AIRWAY**

**RESPIRATION**

**CIRCULATION**

 **HYPOTHERMIA / HEAD INJURIES**

### *AFTER* LIFE-THREATENING

**PAIN**

**ANTIBIOTICS**

**WOUNDS**

**SPLINTING**



## EYE INJURIES OVERVIEW

### **EYE INJURIES**

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)

## EYE INJURIES

### WHEN TO SUSPECT A PENETRATING EYE INJURY

1. **Bleeding surrounding the eye, inside the eyeball; or coming from the eyeball**
2. **Obvious penetration of shrapnel or debris into the eyeball or eye socket**
3. **Protruding objects from the globe of the eyeball**
4. **Swelling or lacerations of the globe of the eyeball**
5. **Protrusion of the globe of the eyeball from the eye socket**
6. **Reduced vision and swelling of the eye area**
7. **Misshapen or distorted parts of the eye**





## EYE INJURIES

# IF A **PENETRATING EYE INJURY** IS NOTED OR SUSPECTED

1. Perform a rapid field test of visual acuity and document findings
2. Cover the affected eye with a rigid eye shield (**NOT a pressure patch**)

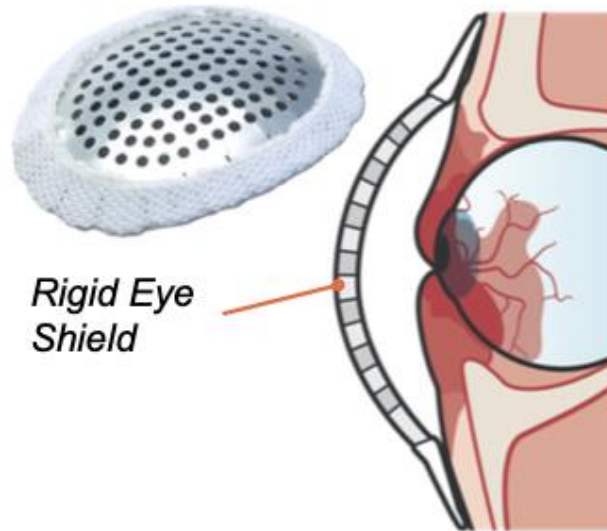
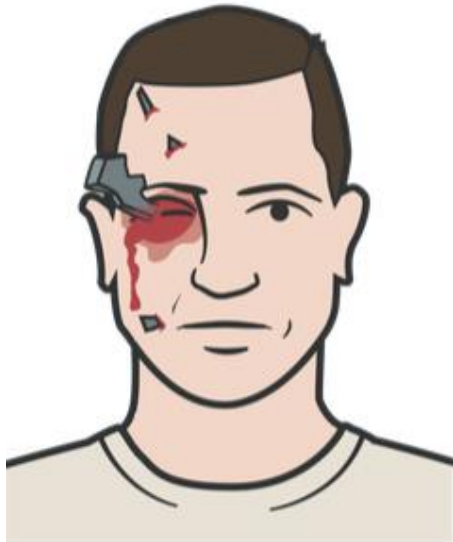
### REMEMBER

- All treatments performed must be documented in the casualty's Cas Card



## EYE INJURIES

# PROTECTING THE EYE



*Rigid Eye  
Shield*

### Apply a rigid eye shield

- When penetrating eye trauma due to shrapnel is suspected, it is critically important to prevent manipulation or additional trauma to the eye that might cause further damage to the eye

### IMPORTANT! DO NOT APPLY PRESSURE

- Avoid/prevent manipulation or additional trauma to the eye that might cause further damage
- Pressure on the eye could force the interior contents of the eye out of the eyeball through a cut or laceration

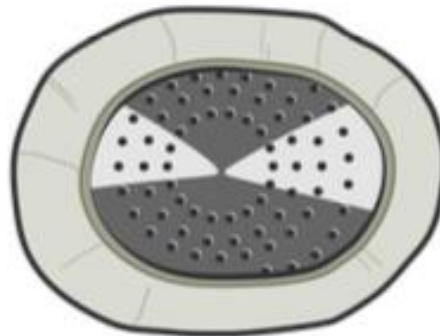
## EYE INJURIES

# APPLYING RIGID EYE SHIELD

The rigid eye shield is found in BFAK; if eye shield is not available, use casualty's tactical eyewear to protect the injured eye

Secure the rigid eye shield with tape at 45-degree angles across the forehead and cheek

- Do **NOT** cover both eyes unless both eyes are injured



## REMEMBER

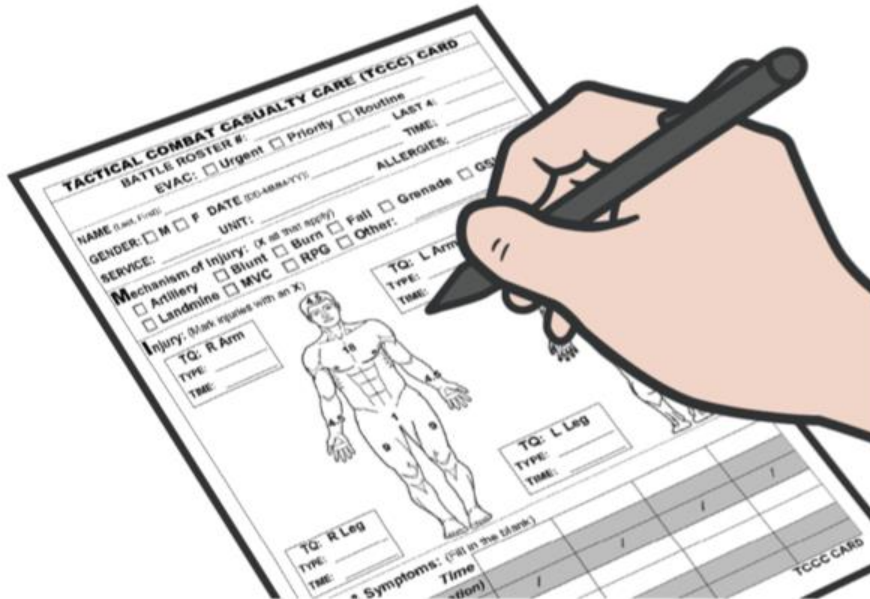
- Rigid eye shields should be placed over both eyes only when you are sure or at least strongly suspect that both eyes have been injured
- If the casualty is conscious, request Medic assistance for administration of the WMP





## EYE INJURIES

# DOCUMENT TREATMENT



- Document all assessments and treatment on the **Casualty Card**
- Be sure to include any medications administered and the time administered

## APPLYING THE RIGID EYE SHIELD

### **RIGID EYE SHIELD APPLICATION**

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)

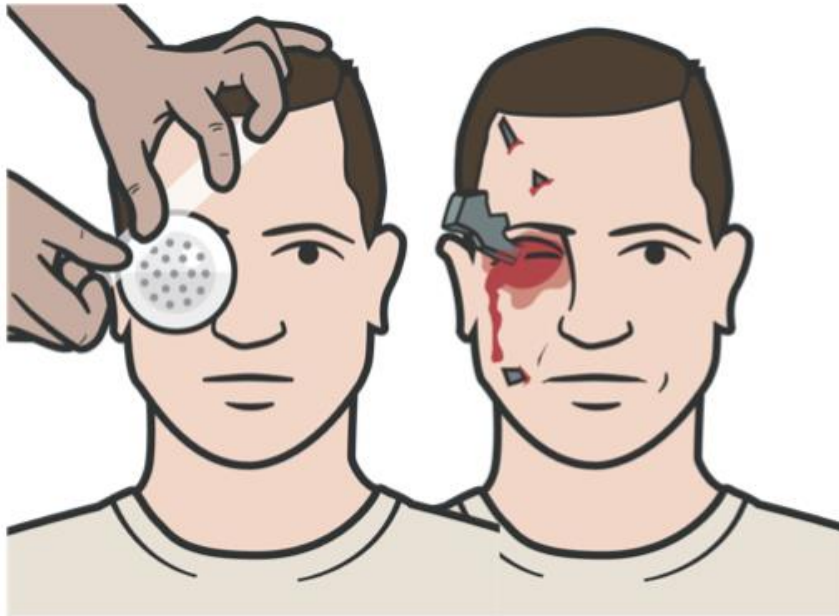
## SKILL STATION

### Rigid Eye Shield (Skills)

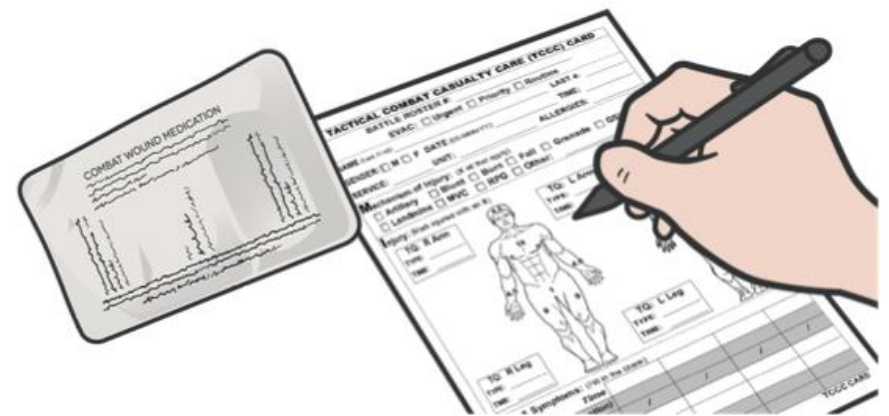
- Rigid Eye Shield

DRAFT

## SUMMARY



- We identified **eye injuries**
- We discussed eye injury **treatment**
- We discussed **applying** an eye shield
- We discussed **documentation**



## CHECK ON LEARNING

- What kind of dressing should be used on penetrating eye trauma with an impaled object?
- True or False: Protecting the injured eye with an eye shield is just as safe as using a patch or a pressure dressing.
- True or False: Only the injured eye should be covered with an eye shield.



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## MODULE 14: ANALGESICS AND ANTIBIOTICS

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

### **T15 Given a combat peacekeeping or non-combat peacekeeping scenario, recommend analgesia administration during Tactical Field Care in accordance with TFMA Guidelines**

**E073** Assist Medic to identify the indications and considerations of the analgesia approaches in Tactical Field Care

**E074** Assist Medic to identify the indications, contraindications, and administration methods of acetaminophen in Tactical Field Care

**E075** Assist Medic to Identify the indications, contraindications, and administration methods of analgesics (pain medications) in Tactical Field Care

**E076** Assist Medic in administration of a Wound Medication Pack in Tactical Field Care

### **T16 Given a combat peacekeeping or non-combat peacekeeping scenario, assist Medic to perform antibiotic administration during Tactical Field Care in accordance with TFMA Guidelines**

**E077** Assist Medic to identify the evidence and considerations for early antibiotic administration in Tactical Field Care

**E078** Assist Medic to identify the indications, contraindications, and administration methods of antibiotics in Tactical Field Care



## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

**NOTE:** This is covered in more advanced TFMA training!



YOU ARE HERE

## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**M**ASSIVE BLEEDING **#1 Priority**

**A**IRWAY

**R**ESPIRATION

**C**IRCULATION

**H**YPOTHERMIA / HEAD INJURIES

### *AFTER* LIFE-THREATENING

➤ **P**AIN

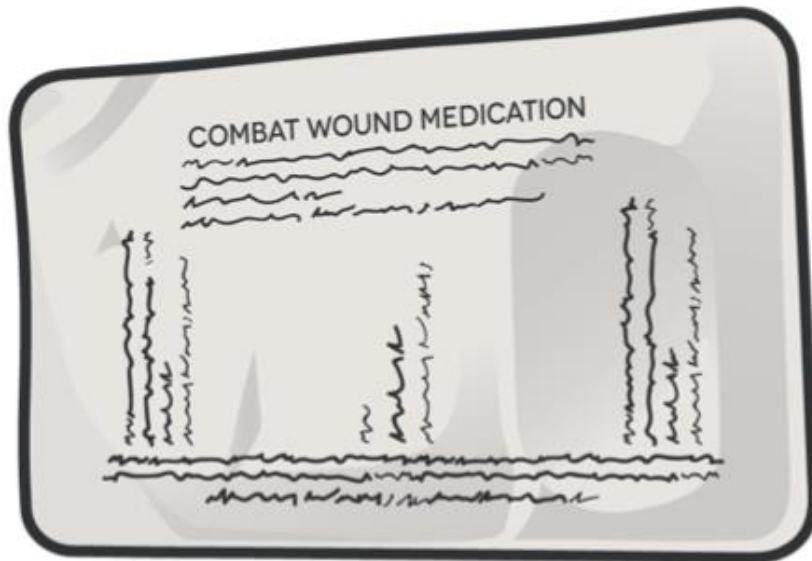
➤ **A**NTIBIOTICS

**W**OUNDS

**S**PLINTING

## PAIN MEDICATION & ANTIBIOTIC ADMINISTRATION

### EXAMPLE OF A WOUND MEDICATION PACK (WMP)



#### WMP

- Found in Medics kit
- Contains medication taken by mouth
- Document all medications administered (and time given) on UN Casualty Card

## PAIN MEDICATION & ANTIBIOTIC ADMINISTRATION

# WMP PAIN MANAGEMENT CONSIDERATIONS

**Examples of pain medication  
(#1 and #3)  
antibiotic (#2)**



**1**

acetaminophen  
pain management



**2**

moxifloxacin  
antibiotic



**3**

meloxicam  
anti-inflammatory

## ANALGESIA ADMINISTRATION OVERVIEW

### **ANALGESIA ADMINISTRATION**

**FMA may ONLY assist a Medic**

**Remember other methods of pain control:**

- **Splinting**
- **Wound dressing**
- **Burn covering**
- **Distraction and reassurance**

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)



## ANTIBIOTICS OVERVIEW

**ANTIBIOTICS ADMINISTRATION**  
**FMA may ONLY assist a Medic**

Video can be found on [DeployedMedicine.com](https://DeployedMedicine.com)

## PAIN MEDICATION & ANTIBIOTIC ADMINISTRATION

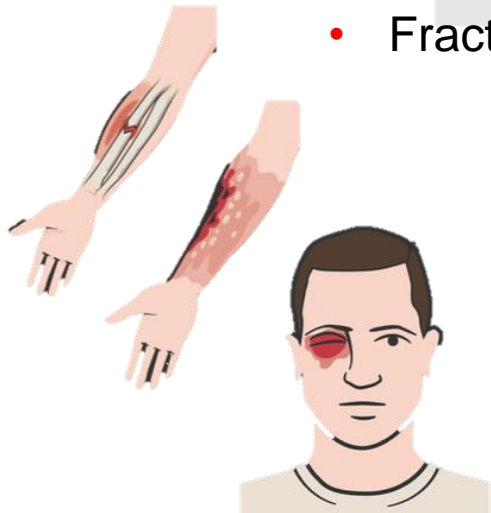
### WOUND MEDICATION PACK

- Mild to moderate pain
- Casualty is still able to fight
- Casualty should take all three medications in WMP

#### COMBAT WOUND MEDICATION PACK

Video can be found on  
[DeployedMedicine.com](https://DeployedMedicine.com)

- Fractures



- Burns

- Eye Injuries

**Note:** If casualty has wounds or pain severe enough to render them unable to fight, the Medic has other options to treat pain

These meds will generally require that the casualty be disarmed, as they can result in the alteration of a casualty's mental status

## PAIN MEDICATION & ANTIBIOTIC ADMINISTRATION

### WHEN TO ASSIST THE MEDIC TO GIVE WMP



#### **GIVE**

- Conscious and able to swallow
- Has mild to moderate pain
- Is still able to fight if needed
- Has penetrating wounds or break in the skin



#### **DON'T GIVE**

- Unable to swallow or take oral meds (unconscious or severe facial trauma/burns)
- Known allergies

**Refer to Medic if unconscious**

**Note:** If the casualty has a break in the skin resulting from a traumatic injury, the casualty should take the WMP; otherwise, consult with Medic before taking



## SKILL STATION

Analgesia/Antibiotics(Skills)

- WMP

DRAFT

## SUMMARY

- Only a Medic may administer drugs assisted by FMA
- Battlefield wounds can be very dirty and susceptible to infection; early administration of antibiotics may reduce the chance of later infections
- Wound infections can kill the casualty or delay their recovery
- WMP should be given **ASAP** for wounds **after life-threatening** issues have been addressed



**WMP** should be given for any  
**penetrating wounds**

## CHECK ON LEARNING

- FMA may give drugs?
- True or False: The WMP contains pain medication and antibiotics.
- How should the WMP be taken?
- Who should take the WMP?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## MODULE 15: WOUND MANAGEMENT

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant



You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**T17** Given a combat peacekeeping or non-combat peacekeeping scenario, perform assessment and initial management of wounds during Tactical Field Care in accordance with TFMA Guidelines

**EO79** Identify wound management considerations in Tactical Field Care

**EO80** Demonstrate application of wound dressings on a trauma casualty in Tactical Field Care

## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

**NOTE:** This is covered in more advanced TFMA training!



YOU ARE HERE

## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**MASSIVE BLEEDING** #1 Priority

**AIRWAY**

**RESPIRATION**

**CIRCULATION**

**HYPOTHERMIA / HEAD INJURIES**

### *AFTER* LIFE-THREATENING

**PAIN**

**ANTIBIOTICS**

**➤ WOUNDS**

**SPLINTING**



## WOUND MANAGEMENT

### CONTINUED REASSESSMENT

Once applied, continue to check the casualty's hemorrhage control interventions and wound management; do not apply and forget about it!

All wounds must be **FREQUENTLY REASSESSED**  
to ensure continued hemorrhage control

**BLEEDING IS THE #1 CAUSE OF PREVENTABLE  
DEATH ON THE BATTLEFIELD**

## WOUND MANAGEMENT

# CONFIRM ALL WOUNDS ARE ACCOUNTED FOR



Observe for blood flowing around or under:

- TQs, bandages, and dressings

If bleeding has not been controlled:

- Tighten the TQ
- Tighten the pressure bandages
- Redress the wounds
- Reassess prior life-threatening wounds to ensure bleeding is still controlled

## WATCH FOR REBLEEDING!

## WOUND MANAGEMENT

# TREAT FOR RE-BLEEDING

- Pack any wounds that continue to bleed with hemostatic dressing
- Once applied (with pressure for 3 minutes), 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



**ALWAYS REASSESS TREATMENT!**

## WOUND MANAGEMENT

# DRESSINGS AND BANDAGES FOR MINOR WOUNDS



Dress any previously untreated wounds by applying (or packing) gauze with direct pressure

- Non-life-threatening bleeding usually does not need hemostatic dressings
- If no dressings or gauze are available, use clean dry cloth (torn clothing, cravats, etc.)

Minor wounds include:

- Minor lacerations
- Abrasions (road rash)

This includes major wounds that are no longer bleeding, such as:

- Amputation stumps
- Gunshot wounds that required TQ
- Major lacerations
- Shrapnel wounds (still in place)
- Impaled objects

## WOUND MANAGEMENT

### REASSESS APPLIED BANDAGES

Assess all applied bandages for:

- **Increased** pain
- Pale or bluish **skin**
- **Pulse**

**This might indicate an emergency!**

Ensure the applied bandage **isn't too tight**; loosen as needed while keeping the bleeding controlled



**DO NOT EVER APPLY IT AND FORGET IT!**

**MARCH PAWS**



## SKILL STATION

### Wound Management (Skill)

- Wound dressing

DRAFT



## SUMMARY



- We defined **reassessment**
- We discussed **re-bleeding**
- We discussed treatment for **minor wounds**
- We discussed **reassessing** bandages



## CHECK ON LEARNING

- Why should all dressed wounds be continuously reassessed?
- When should minor wounds be addressed?

DRAFT





# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## **MODULE 16: BURN TREATMENT**

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**T18** Given a combat peacekeeping or non-combat peacekeeping scenario, perform assessment and initial treatment of burns during Tactical Field Care in accordance with TFMA Guidelines

**EO81** Identify the specific scene safety issues and actions required of a trauma casualty with burns, before evaluation and care of the casualty

**EO82** Identify the severity of burn in accordance with the conventional burn classification

**EO83** Identify how to estimate the body surface area burned using the Rule of Nines

**EO84** Demonstrate the application of a dry dressing to a burn casualty in accordance with TFMA guidelines

**EO85** Demonstrate techniques used to prevent heat loss in a severe burn casualty in accordance with TFMA guidelines

## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

**NOTE:** This is covered in more advanced TFMA training!



YOU ARE HERE

## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**M**ASSIVE BLEEDING **#1 Priority**

**A**IRWAY

**R**ESPIRATION

**C**IRCULATION

**H**YPOTHERMIA / HEAD INJURIES

### *AFTER* LIFE-THREATENING

**P**AIN

**A**NTIBIOTICS

**W**OUNDS

**S**PLINTING

## BURN CARE

### **FOLLOW MARCH PAWS**

- Address **ALL OTHER** life-threatening injuries using the MARCH PAWS sequence
- All trauma treatments can be performed on or through burned skin



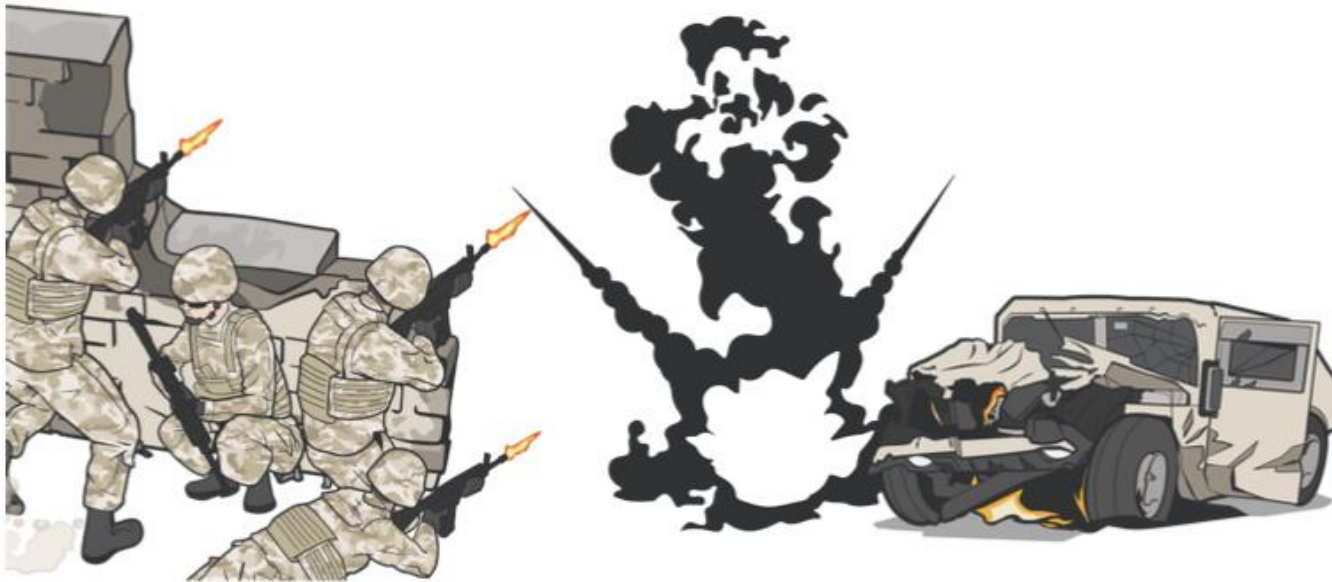
### **Remember**

- A burned trauma casualty is a trauma casualty first



## BURN CARE

### POTENTIAL CAUSES



**FIREFIGHTS**

**EXPLOSION  
(IED/VBIED)**

**VEHICLE/  
AIRCRAFT  
CRASHES**



**ELECTRICAL**



**THERMAL**



**CHEMICAL**



## BURN CARE

# ELECTRICAL



- Secure the power, if possible; otherwise, remove the casualty from the electrical source using a nonconductive object, such as a wooden stick
- Move the casualty to a safe place

**IN CASE OF  
ELECTRICAL INJURY**



## BURN CARE

### THERMAL



- Stop the source of the burn
- Cut clothing around the burned area and gently lift away

If clothing is stuck to the burn, ensure you cut around the clothing and leave it in place

### IN CASE OF THERMAL INJURY

- Be sure to avoid grabbing the burned area while moving/picking up the casualty

## BURN CARE

### CHEMICAL



### IN CASE OF CHEMICAL INJURY

#### EXAMPLE

- White phosphorus

#### SOURCE

- Commonly found in tank rounds, mortar rounds, artillery rounds

#### TREATMENTS

- Submerge the burned area in water
- Apply wet barrier (water-soaked gauze, clothing, mud, etc.) with an occlusive dressing
- Advise medical personnel **immediately**



## BURNS OVERVIEW

**BURNS**

DRAFT

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)

## BURN CARE

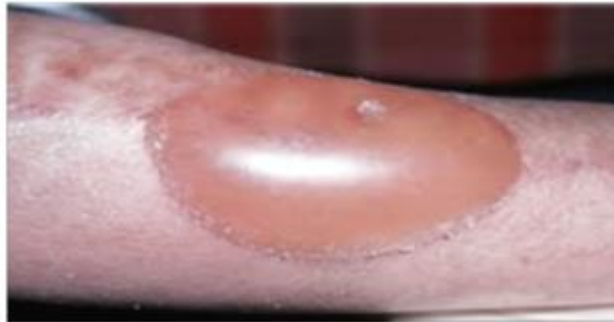
### SEVERITY OF BURN

**BURNS ARE CLASSIFIED BY THE DEPTH OF THE WOUND**



#### **SUPERFICIAL 1ST-DEGREE BURNS**

are just like a sunburn, with a reddened appearance of the skin



#### **PARTIAL THICKNESS 2ND-DEGREE BURNS**

will also have blisters



#### **FULL THICKNESS 3RD-DEGREE BURNS**

may appear dry, stiff, and leathery, and/or can also be white, brown, or black

## BURN ESTIMATION

# RULE OF NINES

### Rule of Nines

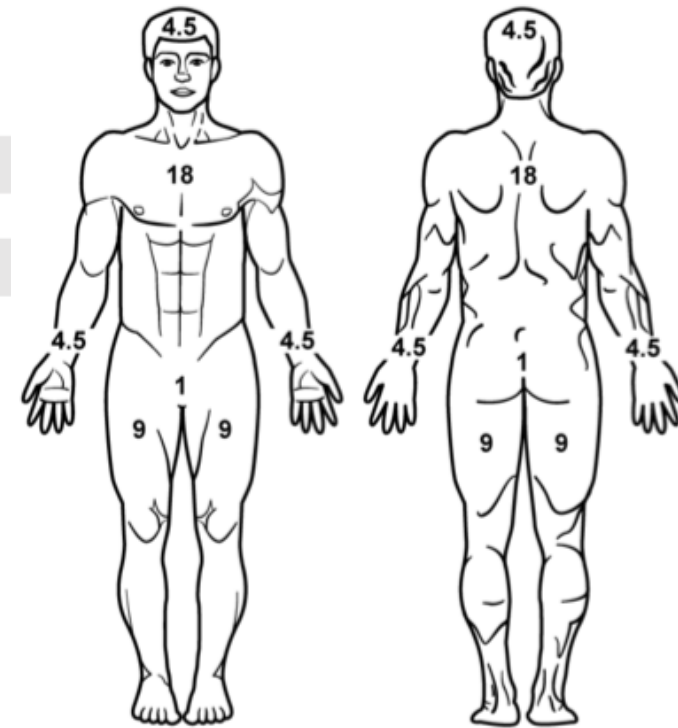
**11** areas that each have **9% body surface area** (head, arms, front and backs of legs, and front and back of the torso having **TWO 9% areas**)

- **Palm size** represents ~1%
- **Estimate/round up to nearest 10**

If half of the front or rear area **is burned**, the area would be **half** of the **area value**

### ESTIMATION EXAMPLE

- **Half** of the front upper/lower leg is **4.5%**
- **Half** of the front upper/lower torso is **9%**





## BURN CARE

## BURN CARE



### REMOVE

watches and jewelry from  
burned area



### COVER

the burn area with dry,  
sterile dressings



### COVER

burns from **white  
phosphorus** with **wet**  
dressings

## BURN MANAGEMENT

# BURN CARE + HYPOTHERMIA PREVENTION

### Passive Warming Supplies



For **extensive burns (>20%)**, consider using **active** warming supplies to cover the burned areas and prevent hypothermia



- Burn patients are particularly susceptible to hypothermia
- Extra emphasis should be placed on barrier heat loss prevention methods

### Facial Burns

- Facial burns, especially those that occur in closed spaces, may be associated with inhalation injury
- These casualties should be monitored closely for potential airway issues
- **DO NOT** place NPA in casualty with signs of inhalation burns

## SKILL STATION

### Burn Treatment (Skill)

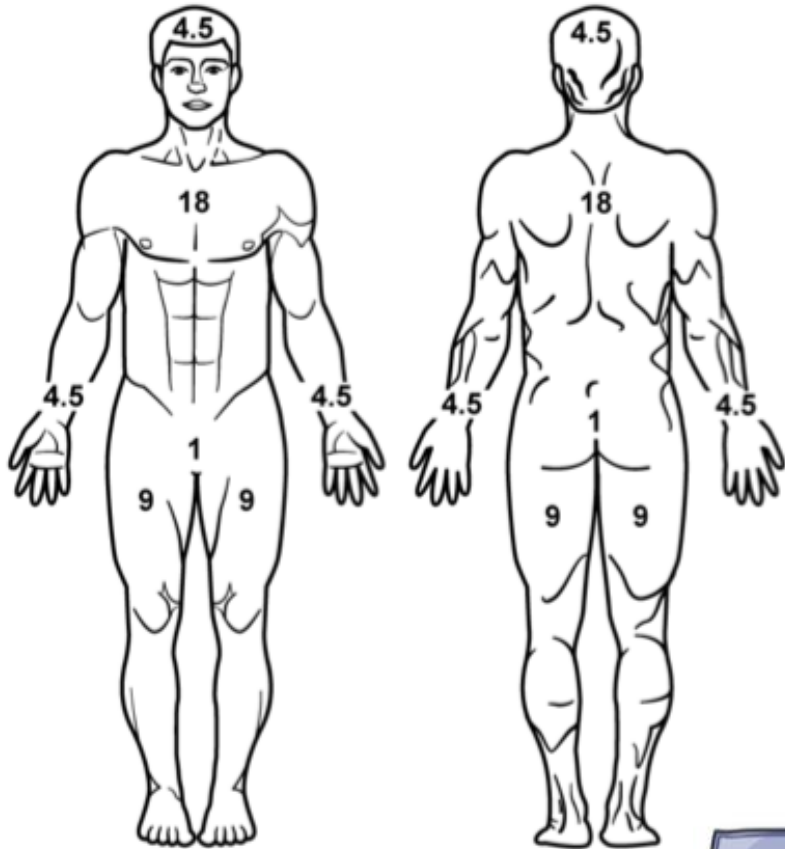
- Burn dressing

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## SUMMARY



- We discussed **treatment priorities**
- We discussed **potential causes** of burns
- We identified **electrical** burns
- We identified **thermal** burns
- We identified **chemical** burns
- We discussed the **Rule of Nines**
- We discussed burns **and** hypothermia
- We discussed the **prevention of hypothermia**



**ELECTRICAL**



**THERMAL**



**CHEMICAL**

## CHECK ON LEARNING

- What kind of dressing should be placed on burned areas?
- What should you do first when you encounter a casualty with an electrical burn?
- What should you do first when you encounter a casualty with a thermal burn?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## **DRAFT**

### MODULE 17: FRACTURES

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**T19** Given a combat peacekeeping or non-combat peacekeeping scenario, perform assessment and initial management of fractures during Tactical Field Care in accordance with TFMA Guidelines

**EO86** Identify signs of a suspected fracture

**EO87** Demonstrate the basic care of fractures in accordance with TCCC Guidelines

**EO88** Demonstrate proper splint application using a malleable rigid or improvised splint to a suspected fracture in Tactical Field Care

## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

**NOTE:** This is covered in more advanced TFMA training!



YOU ARE HERE

## TACTICAL FIELD CARE

# MARCH PAWS

### *DURING* LIFE-THREATENING

**MASSIVE BLEEDING** #1 Priority

**AIRWAY**

**RESPIRATION**

**CIRCULATION**

**HYPOTHERMIA / HEAD INJURIES**

### *AFTER* LIFE-THREATENING

**PAIN**

**ANTIBIOTICS**

**WOUNDS**

**➤ SPLINTING**

## FRACTURES

# ASSESS FOR A FRACTURE



### **CLOSED** FRACTURE

No open wound  
(break in skin) for  
closed fracture



### **OPEN** FRACTURE

Open fracture open  
wound (break in  
skin) major threat  
for infection

### **WARNING SIGNS OF A FRACTURE:**

- Significant pain and swelling
- An audible or perceived “snap”
- Different length or shape of limb
- Loss of pulse or sensation in the injured arm or leg
- Crepitus (hearing a crackling or popping sound under the skin)



## FRACTURES

# OBJECTIVES OF SPLINTING

**A splint is used to prevent movement and hold an injured arm/leg in place to:**

1. Identify the location of the fracture  
**NOTE:** Have the casualty or someone else manually stabilize the area
2. Check the distal pulse (pulse below the fracture) and capillary refill (color returning to the nail bed after pressing on it) on the injured extremity before applying the splint
3. Prepare the splint materials for application  
**NOTE:** Measure and shape the splint on the opposing uninjured extremity
4. Prepare securing materials (cravats, elastic wraps/bandages, etc.)
5. Apply the splint to the injured extremity with the limb, in the position of function (a normal resting position), if possible  
**NOTE:** If possible, lightly pad all voids within the splint to make it more comfortable
6. Secure the splint in place with appropriate materials
7. Ensure the joints above and below the fracture are immobilized in the splint whenever possible
8. Recheck the distal pulse following application of the splint. If the pulse is not palpable, loosen the splint, reposition, and reapply the splint
9. Refer to the Medic to administer the pain medications (from the Wound Medication Pack) as needed and the antibiotic for any open fracture(s)
10. Document all treatment on a Casualty Card and attach it to the casualty

## FRACTURES

### PRINCIPLES OF SPLINTING

- Check for other associated injuries
- Use malleable or rigid materials
- Try to pad all voids or wrap if using rigid splint
- Secure splint with elastic bandage, cravats, belts, tape
- Try to splint before moving the casualty
- Minimize manipulation of the extremity before splinting
- Incorporate one joint above and below the fracture
- Splint arm fractures to the shirt using the sleeve, if needed
- Check distal pulse and skin color before and after splinting



## SPLINTING

### THINGS TO AVOID WHEN SPLINTING

- Manipulating the fracture site too much resulting in pain, additional damage to blood vessels and nerves, etc.
- Securing too tightly, cutting off blood flow
- Failing to immobilize joint above and below fracture when possible
- Causing further injury
- Making casualty uncomfortable during transport/evacuation
- Splinting near or over a wound that has not be properly treated

## SPLINTING

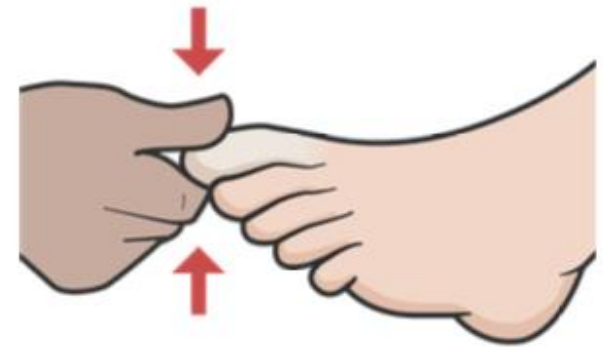
# GUIDELINES FOR **LEG** SPLINTS



Identify the location of the fracture



Before applying the splint, **CHECK** distal pulse (pulse below the fracture)



**CHECK** capillary refill (color returning to the nail bed after pressing on it) on the injured extremity before applying the splint

Have the casualty or someone else manually stabilize the area

## SPLINTING

# GUIDELINES FOR **LEG** SPLINTS



**PREPARE** the splint materials for application

Measure and shape the splint on the opposing uninjured extremity



**PREPARE** securing materials (cravats, elastic wraps/ bandages, etc.)



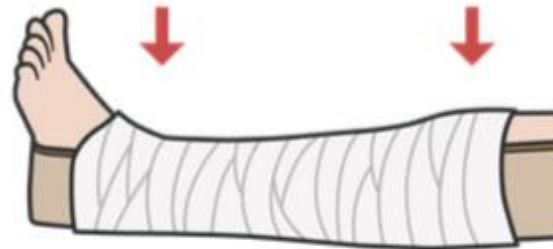
**APPLY** the splint to the injured extremity with the limb, in the position of function, a normal resting position, if possible

## FRACTURES

# GUIDELINES FOR **LEG** SPLINTS



**SECURE** the splint in place with appropriate materials



**ENSURE** the joints above and below the fracture are immobilized in the splint whenever possible



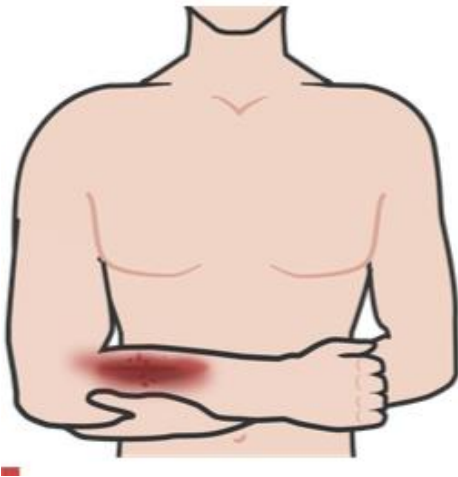
**RECHECK** the distal pulse following application of the splint

If the pulse is **not** palpable, loosen the splint, reposition, and reapply

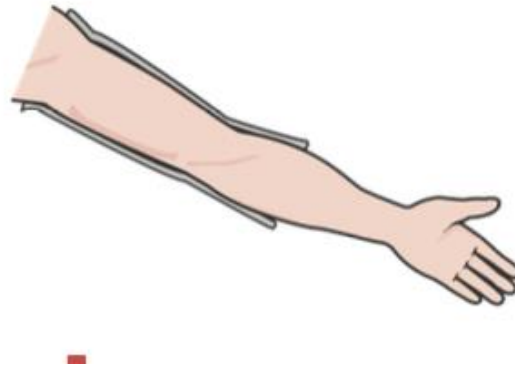
## SPLINTING

### GUIDELINES FOR **ARM** SPLINTS

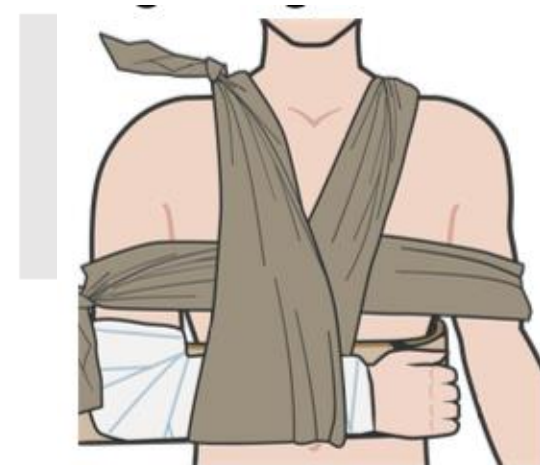
Splinting the arm is the same concept as splinting a leg with the following exceptions:



If possible, have casualty support their injury while preparing equipment



Mould padded splint using casualty's unaffected limb

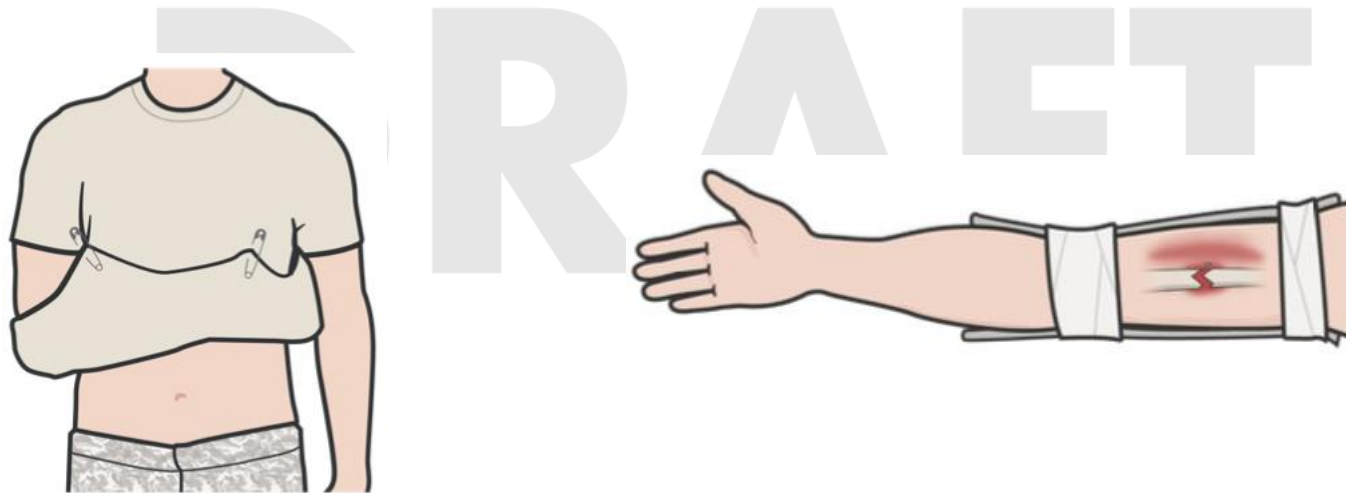


Use two triangular bandages to secure limb to body

Use third triangular bandage; place under injured arm and around neck to help support injured limb

## SPLINTING

# GUIDELINES FOR **ARM** SPLINTS



- Check for signs of impaired circulation
- Apply a sling to immobilize the forearm
- Apply a swathe to immobilize the upper arm
- Place two cravats above the fracture site and two below the fracture site (preferred)





## SPLINTING AN ARM

**SPLINTING**  
**(TACTICAL FIELD CARE)**

Video can be found on [DeployedMedicine.com](https://www.deployedmedicine.com)



## SKILL STATION

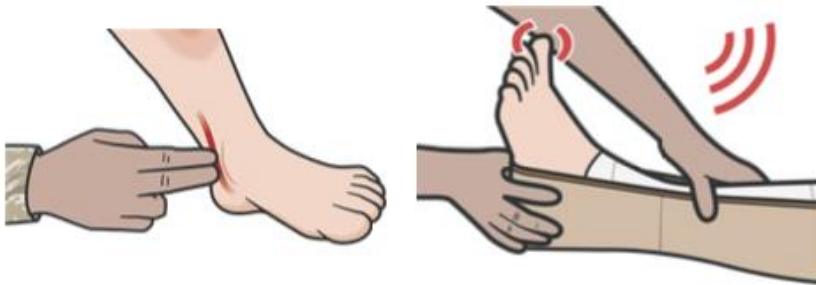
Splinting (Skill)

- Splinting

DRAFT

## SUMMARY

- The most important aspect of splinting is to splint in a way that does not harm the nerves or blood vessels in the splinted extremity
- **Before** and **after** splinting, **assess** the following:



### CIRCULATION

Check pulses distal to the splint (between splint and end of limb)



### MOTOR

Ask the casualty to move the body parts distal to the splint, e.g., fingers or toes



### SENSORY

See if the casualty can feel a gentle touch on the body parts distal to the splint



### AFTER SPLINTING

Document all assessment and treatment on the Casualty Card

## CHECK ON LEARNING

- True or False: When applying a splint, ensure the joints above and below the fracture are immobilized in the splint whenever possible.
- What should you assess before and after splinting?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## MODULE 18: CASUALTY MONITORING

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant



You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**T20** Given a combat peacekeeping or non-combat peacekeeping scenario, perform monitoring of a trauma casualty during Tactical Field Care in accordance with TFMA Guidelines

**EO89** Identify the methods to assess level of consciousness, pulses, and respiratory rate on a trauma casualty in Tactical Field Care

**EO90** Demonstrate assessment of radial/carotid pulse and respirations in a trauma casualty in Tactical Field Care

## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

**NOTE:** This is covered in more advanced TFMA training!



YOU ARE HERE



## CASUALTY MONITORING

# ASSESSMENT USING MARCH PAWS

Re-bleeding

**M**ARCH

**M**ASSIVE BLEEDING

Check for re-bleeding on any  
previous treatments

Management

**M**ARCH

**A**IRWAY

Ensure airway remains open and  
unobstructed

Reassess casualty every 5–10 minutes  
for change in status until handoff with  
medical personnel

CASUALTY MONITORING

## ASSESSMENT USING MARCH PAWS (CONT.)

Breathing Rate

**MARCH**

**RESPIRATION**  
**BREATHING**

Pulse

**MARCH**

**CIRCULATION**

Level of Consciousness

**MARCH**

**HYPOTHERMIA**  
**HEAD INJURIES**

- Document any changes in status on the casualty's Cas Card.
- If medical personnel arrive in the middle of reassessment, stop and hand off casualty immediately

## CASUALTY MONITORING

# LEVEL OF CONSCIOUSNESS

- Check every 15 minutes (or if seriously wounded every 5–10) for decrease in AVPU:

**A**lert

**V**erbal

**P**ain

**U**nconscious

- This could indicate condition worsening
- If casualty is not **ALERT**, indicating decreased mental status, the casualty should not have weapons or communications equipment





## AVPU ASSESSMENT HOW-TO

# DRAFT

### AVPU ASSESSMENT (TACTICAL FIELD CARE)

Video can be found on [DeployedMedicine.com](https://DeployedMedicine.com)

## CASUALTY MONITORING

# CHECKING PULSE



### **CAROTID** (neck)

If casualty status is noted to be deteriorating when assessed, reassess using the MARCH PAWS sequence



### **RADIAL** (wrist)

No radial pulse is an indicator of shock

## ASSESSING RADIAL & CAROTID PULSE

Video can be found on  
[DeployedMedicine.com](https://www.deployedmedicine.com)

## IMPORTANT CONSIDERATIONS

Measure the number of felt heartbeats in 1 MINUTE and record on Casualty Card

## CASUALTY MONITORING

# CHECKING RESPIRATIONS

**LOOK, LISTEN and FEEL FOR RESPIRATIONS**

- If a casualty becomes unconscious or their breathing rate drops below **8 respirations within 1 MINUTE**, insert a nasopharyngeal airway
- Assess for tension pneumothorax and treat as necessary
- Perform needle decompression in the presence of tension pneumothorax
- **Reassess** to confirm that needle decompression of the chest (NDC) was successful





## SKILL STATION

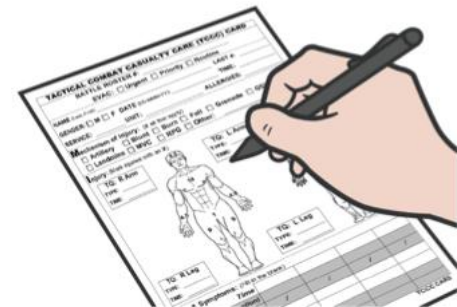
### Casualty Monitoring Concepts (Skills)

- Level of consciousness
- Radial pulse
- Carotid pulse
- Tibial pulse

## SUMMARY

### LOOK, LISTEN and FEEL FOR RESPIRATIONS

- We discussed assessment using **MARCH PAWS**
- We discussed levels of consciousness
- We discussed checking for pulse
- We discussed checking respirations





## CHECK ON LEARNING

- How is a casualty monitored after the MARCH PAWS sequence has been executed?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## MODULE 19: PRE-EVACUATION PROCEDURES

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**T21** Given a combat peacekeeping or non-combat peacekeeping scenario, perform pre-evacuation procedures during Tactical Field Care in accordance with TFMA Guidelines

- EO91** Identify the importance of and techniques for communicating casualty information with evacuation assets and/or receiving facilities
- EO92** Identify the information requirements and format of an evacuation request
- EO93** Identify the recommended evacuation prioritization for peacekeeping casualties
- EO94** Demonstrate the communication of evacuation request information and modified medical information report requirements

**T22** Given a combat peacekeeping or non-combat peacekeeping scenario, perform documentation of care during Tactical Field Care in accordance with TFMA Guidelines

- EO95** Identify how to document casualty information on the Casualty Card and the proper placement of that card on the casualty.
- EO96** Demonstrate the proper documentation of care on a trauma casualty in Tactical Field Care

## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

YOU ARE HERE



**NOTE:** This is covered in more advanced TFMA training!

## PRE-EVACUATION COMMUNICATION



### **Communicate with the casualty if possible**

- Encourage
- Reassure
- Explain care each step of the way



### **Communicate immediately with tactical leader for**

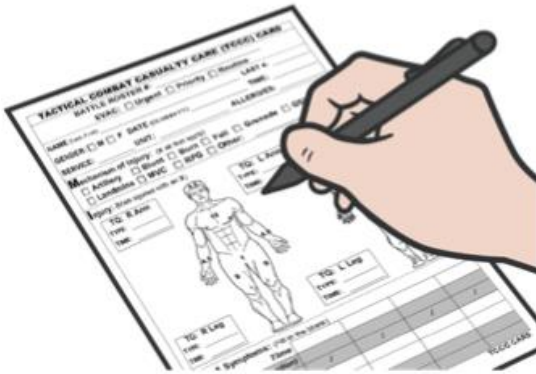
- Status
- Evac requirements
- Casualty treatment

### **COMMUNICATE WITH EVACUATION AND MEDICAL ASSETS**

- Communicate with evacuation system to coordinate EVAC using 4-Line CASEVAC request
- Keep the Casualty Card up to date

## PRE-EVACUATION

# COMMUNICATE **RELEVANT** CASUALTY DATA



Document all assessment and medical care (including interventions and medications) on the Casualty Card



Communicate with evacuation system:

- 4-Line CASEVAC request
- **MIST** Report
  - M**echanism of injury
  - I**njuries
  - S**ymptoms
  - T**reatment
- Relay the information following your standard operating procedures (SOPs)

## **HANDOFF WITH MEDIC OR CASEVAC**

- When handing off the casualty to the Medic or CASEVAC, provide the Casualty Card, including any additional information as needed
- MIST report
- May change as the casualty status and interventions performed change
- Conveys additional evacuation information that may be required by
- Helps better prepare peacekeeping commanders receiving facility

## PRE-EVACUATION

# REQUESTING EVACUATION OF CASUALTIES

- Although the Field Medical Assistant is not a medical person, they may need to initiate the medical evacuation request
- Depending on the tactical situation and available assets, the casualty may be evacuated by **CASEVAC**



### CASEVAC

Movement of a casualty from Point of Injury to a Medical Treatment Facility



## PRE-EVACUATION

# MEDEVAC REQUEST KEY POINTS

### 9-LINE MEDEVAC / MIST REPORT

Video can be found on  
[DeployedMedicine.com](https://DeployedMedicine.com)

**BE AWARE:** This video demonstrates the TCCC 9-LINE MEDEVAC. The UN equivalent is the 4-LINE CASEVAC.

- **Every** UN member must be prepared to transmit a CASEVAC request
- A CASEVAC request is **NOT** a direct medical communication with medical providers, but a means of communicating evacuation requirements so aircraft resources can be launched as needed
- Gather **all** information needed **before** initiating transmission
- Use **appropriate and mandated communications security and brevity codes** when transmitting a CASEVAC request in accordance with the operational plan

## PRE-EVACUATION

### 4-LINE: CASEVAC REQUEST LINES 1-4

(4 Line Format)

Line	UN CASEVAC 4-LINE ALERT MESSAGE		
	DTG:		
1	LOCATION AND CALL SIGN	PLACE NAME / DESCRIPTION	A
		GPS GRID REFERENCE	B
		CALL SIGN OF INCIDENT SITE COMMANDER	C
2	INCIDENT DETAILS	WHAT HAS HAPPENED? (Shooting, road accident, explosion etc).	D
		HOW MANY CASUALTIES ARE THERE?	E
3	ACTIONS BEING TAKEN AT SCENE	TREATMENT BEING GIVEN AND PREPERATIONS FOR EVACUATION	
4	RESOURCES REQUIRED AT SCENE TO TREAT AND EVACUATE PATIENT	GROUND AMBULANCE, AIR EVACUATION, AMET	

## SKILL STATION

### Communication and Documentation (Skills)

- 4-Line & Mist Report

DRAFT

## PRE-EVACUATION

# CASUALTY CATEGORIES

Ground medical personnel will determine EVAC categories of casualties  
EXAMPLES:

URGENT	URGENT SURGICAL	PRIORITY	ROUTINE	CONVENIENCE
<2 hours to save life, limb, or eyesight	<2 hours to nearest surgical unit	<4 hours or could deteriorate to urgent	<24 hours	Not a medical necessity
Tourniquets Corrected haemorrhage Traumatic Brain Injuries (TBIs)	Needle Decompression of the Chest (NDCs) Cricothyroidotomy Major internal bleeding Massive head trauma	Compensated shock Broken arm with loss of distal pulse 2nd-degree burns to a large portion of the abdomen or extremities	Abrasions Cardiac arrest Small fractures Frostbite 2nd-/3rd-degree burns >70% of body surface area (BSA)	Used for administrative purposes for casualty movement

## PRE-EVACUATION

# OVER-CATEGORIZATION

**OVER-CATEGORIZATION:** the tendency to classify a wound or injury as being more severe than it actually is

Historically **AND** currently problematic

**Proper** casualty categorization is needed to ensure that those casualties in greatest need are evacuated first and receive the care required to help ensure their **survival**

Casualties will be picked up **as soon as possible**, consistent with available resources and pending missions

- A. Urgent: <2 hours to save life, limb, or eyesight
- B. Urgent Surgical: <2 hours to nearest surgical unit
- C. Priority: <4 hours or could deteriorate to urgent
- D. Routine: <24 hours
- E. Convenience: not a medical necessity



## PRE-EVACUATION

### COMMUNICATE

1. **WITH THE CASUALTY**  
Encourage, reassure,  
and explain care
2. **WITH TACTICAL  
LEADERSHIP**  
Provide leadership with  
the casualty's status and  
location
3. **WITH MEDICAL  
PERSONNEL**  
Discuss with the  
responding medics the  
casualty's injuries and  
symptoms, as well as  
any medical aid provided

### DOCUMENT

1. CASUALTY ASSESSMENT FINDINGS
2. MEDICAL AID RENDERED
3. CHANGES IN CASUALTY STATUS

**MIST Report** is generated from  
Cas Card



## SKILL STATION

Communication and Documentation (Skill) – Cas Card

DRAFT



## SUMMARY

- We discussed the **4-Line** and **MIST** Reports
- We discussed **requesting** an **evacuation** of a casualty
- We identified **over-categorization**
- We identified **key information** to relay to tactical leadership





## CHECK ON LEARNING

- With whom do you communicate in a casualty situation?
- What information does the MIST Report contain?
- Who should complete the Casualty Card?
- Where can you find the Casualty Card?



# FIELD MEDICAL ASSISTANT COURSE (FMAC)

## MODULE 20: EVACUATION PROCEDURES

## TACTICAL FIELD MEDICAL AID (TFMA)

### ROLE-BASED TRAINING SPECTRUM

#### ROLE 1 CARE

##### NONMEDICAL PERSONNEL

- Buddy First Aid
- Field Medical Assistant

You are HERE

##### MEDICAL PERSONNEL

- Paramedic
- Nurse
- Doctor

## STUDENT LEARNING OBJECTIVES

# TERMINAL LEARNING OBJECTIVE

**T23** Given a combat peacekeeping or non-combat peacekeeping scenario, prepare casualties for evacuation during Tactical Field Care in accordance with TFMA Guidelines

**EO97** Identify considerations and fundamental procedures for staging casualties for evacuation

**EO98** Identify the importance of pre-mission evacuation equipment preparation and rehearsals

**EO99** Identify considerations and precautions required for evacuating casualties with suspected spinal injuries

**EO100** Identify critical actions and checks to prepare casualties for evacuation

**EO101** Identify methods of litter selection and evacuation equipment in Tactical Field Care

**EO102** Identify considerations for evacuating ambulatory/walking wounded casualties in Tactical Field Care

**EO103** Demonstrate the preparation of a casualty for evacuating in Tactical Field Care

**EO104** Identify the importance and information considerations of a casualty After Action Review (AAR) submission

## Three PHASES of TFMA

### 1 CARE UNDER FIRE

RETURN FIRE  
AND TAKE COVER

Quick decision-making:

- Consider scene safety
- Identify and control life-threatening bleeding
- Move casualty to safety

### 2 TACTICAL FIELD CARE

COVER AND  
CONCEALMENT

Basic Management Plan:

- Maintain tactical situational awareness
- Triage casualties as required
- MARCH PAWS assessment

### 3 TACTICAL EVACUATION CARE

More deliberate assessment and treatment of unrecognized life-threatening injuries:

- Pre-evacuation procedures
- Continuation of documentation

YOU ARE HERE



**NOTE:** This is covered in more advanced TFMA training!



## EVACUATION PROCEDURES

# IMPORTANT ACTIONS

(IN THIS MODULE)

### SECURE ITEMS



### CHOOSE AND PREP LITTER



### PREP EVAC EQUIPMENT



### PACKAGE CASUALTY FOR EVACUATION



## EVACUATION PROCEDURES

### SECURE CASUALTY'S EQUIPMENT



Secure the casualty's weapon and equipment in accordance with unit SOP or mission requirements



Clear and render safe any weapons evacuated with the casualty



Do not evacuate explosives with the casualty if possible

Keep in mind that receiving medical personnel may not be familiar with the equipment or have a way to secure it

## EVACUATION PROCEDURES

### EVAC EQUIPMENT



Prepped by unit personnel  
while treatment continues

Coordinate other  
EVAC activities

Do not delay getting casualties  
onto litters

Hypothermia is better prevented  
off the ground

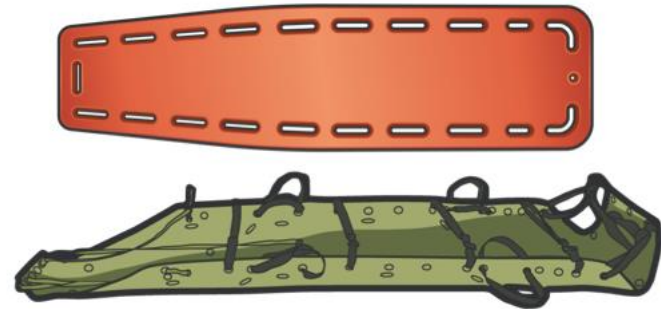
Easier to move casualty on litter

Keep necessary medical  
equipment with the casualty  
(Ex: BVM)



## EVACUATION PROCEDURES

### LITTERS

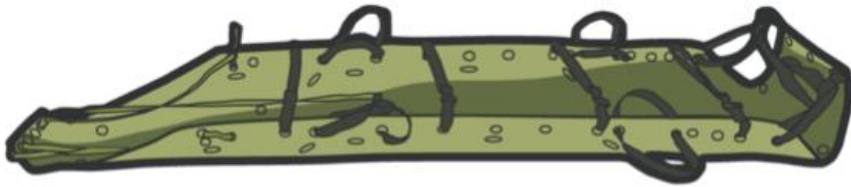


- Casualty movement is easier using litters
- Use best position for care and comfort
- You **DO NOT** have to place casualty on back
- For casualties with spinal injuries, keep spinal column as straight as possible
- **CASUALTY MUST BE SECURED before movement**

- Select litter based on mission or unit
- Consider and train according to operating environment:
  - Equipment
  - Movement
  - Rehearse litter open/setup/carry

## EVACUATION PROCEDURES

### LITTER SELECTION



#### Compact/lightweight transport system

- ✓ Lightweight
- ✗ Rough terrain (if dragging)
- ✓ Two-peacekeeper carry
- ✓ Draggable by one peacekeeper

#### Compact quad-folding litter

- ✓ Small
- ✗ Requires more than one peacekeeper
- ✓ Carrying case
- ✗ May not fit in evacuation vehicle
- ✓ Carried like a rucksack

## EVACUATION PROCEDURES

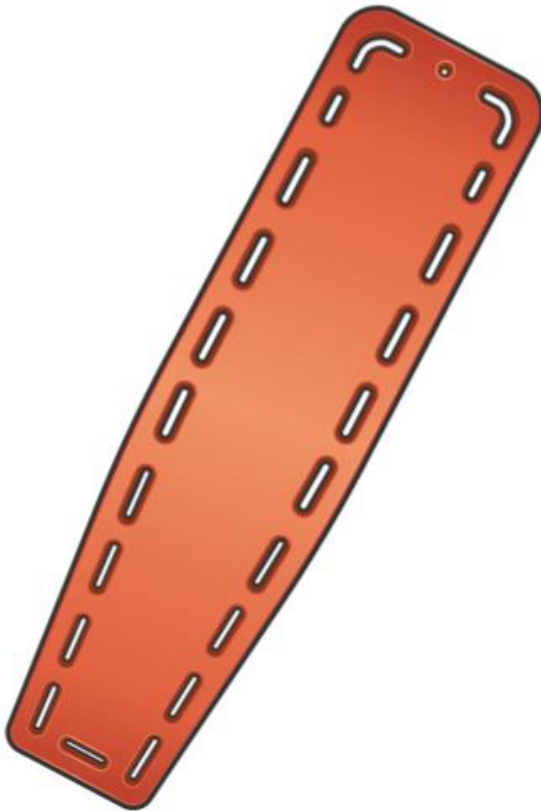
# PACKAGE THE CASUALTY



- Secure loose ends of bandages, medical equipment, and hypothermia prevention materials
- During evacuation, loose materials may get caught and cause further injury to casualties or delays
- Prevent items from being blown by rotor wash or becoming entangled with other equipment
- Blankets and hypothermia materials are especially susceptible to becoming entangled
- Secure the casualty to a litter
- Properly secure completed UN Casualty Card

## EVACUATION PROCEDURES

# EVACUATION CONSIDERATIONS FOR SUSPECTED SPINAL INJURIES



- Events to consider for neck or back injuries: falls, motor vehicle accidents, IEDs, fast-rope injuries, etc.
- Ensure cervical (neck) spine (C-spine) immobilization when spinal cord injury is suspected, if possible  
**Note:** Spine board is requested during 4-Line CASEVAC request
- When considering selection of litter (such as standard litters) based on mission and unit, realize that the selected litter may not fit in the given evacuation ground/air vehicle

## EVACUATION PROCEDURES

### WALKING WOUNDED



- Provide instructions/assistance as needed
- If possible, casualty may assist as a litter bearer/provides security



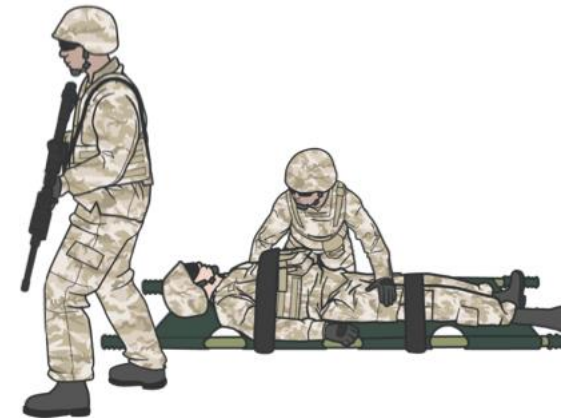
- Guide disoriented / visually impaired casualty's hand-to-shoulder to evacuation platform

#### SELF-CARE

- Instruct casualty to repeatedly check their own wounds and dressings to ensure bleeding remains controlled

## EVACUATION PROCEDURES

### STAGE CASUALTY



- Be prepared for the arrival of the evacuation platform
- Stage the casualties in the loading sequence of the evacuation platform
- Tagging or color-coded chemlights may be used to identify casualty evacuation categories
- Maintain security at the evacuation point in accordance with SOP

## EVACUATION PROCEDURES

# MEDICAL AFTER ACTION REVIEW (AAR)

### **The AAR covers the following**

- What went right?
- What went wrong?
- What can we do better?
- Lessons learned on the casualties and injuries
- Treatment of casualties and effectiveness during mission

Capturing a good AAR ensures up-to-date medical information, types of casualties, and injury patterns that units might encounter and can train for



## SKILL STATION

### Evacuation Procedures – Concepts (Skills)

- Staging for evacuation
- Preparing pre-mission evacuation equipment and rehearsing
- Evacuating casualties with suspected spinal cord injuries
- Preparing casualties for evacuation
- Selecting litter and evacuation equipment in TFC
- Evacuating ambulatory casualties in TFC
- Submitting the AAR
- Submitting/handing off the 4-Line CASEVAC report



## SUMMARY



- We identified important actions
- We discussed securing casualty equipment
- We discussed evacuation equipment
- We identified litter selections
- We discussed casualty packaging
- We identified spinal injury considerations
- We discussed walking wounded
- We identified staging
- We identified considerations for casualty AAR

## CHECK ON LEARNING

- What actions are needed to prepare for evacuation?
- What does casualty staging involve?