TACTICAL COMBAT CASUALTY CARE (TCCC) ROLE-BASED TRAINING SPECTRUM
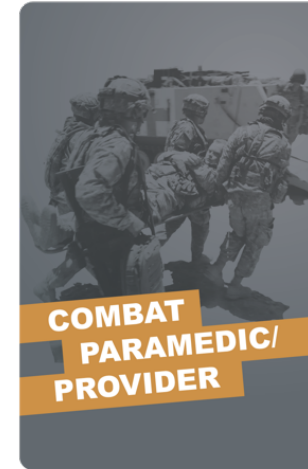

ROLE 1 CARE

NONMEDICAL PERSONNEL

MEDICAL PERSONNEL

ALL SERVICE MEMBERS

COMBAT LIFESAVER

COMBAT MEDIC/ CORPSMAN

COMBAT PARAMEDIC/ PROVIDER

◀ YOU ARE HERE

STANDARDIZED JOINT CURRICULUM

1 x TERMINAL LEARNING OBJECTIVES

24 | **Given a combat or noncombat scenario, perform communication during Tactical Field Care in accordance with CoTCCC Guidelines.**

● **24.1** Identify the importance of and techniques for communicating casualty information with evacuation assets and/or receiving facilities.

● **24.2** Identify the information requirements and format of an evacuation request.

● **24.3** Identify the recommended evacuation prioritization for combat casualties.

○ **24.4** Demonstrate the communication of evacuation request information and modified medical information report requirements.

4 x ENABLING LEARNING OBJECTIVES

= **Terminal Learning Objectives**   ● = Cognitive ELOs   ○ = Performance ELOs

Three <u>PHASES</u> of TCCC

1 **CARE UNDER FIRE (CUF) / THREAT**

RETURN FIRE AND TAKE COVER

2 **TACTICAL FIELD CARE (TFC)**

WORK UNDER COVER AND CONCEALMENT

3 **TACTICAL EVACUATION CARE (TACEVAC)**

MORE DELIBERATE ASSESSMENT AND PRE-EVACUATION PROCEDURES

YOU ARE HERE

IMPORTANCE OF COMMUNICATION

Communicate with **the casualty** if possible:

- Encourage
- Reassure
- Explain care being given

Communicate as soon as possible with **tactical leadership** and **other prehospital medical providers**:

- Casualty status
- Evac requirements and priority
- Casualty treatment

Communicate with **evacuation and medical assets**

- Communicate with **evacuation system** to coordinate TACEVAC (CASEVAC or MEDEVAC) using 9-Line MEDEVAC request
- MIST report
- Keep the casualty's DD Form 1380 up-to-date

REQUESTING
EVACUATION OF CASUALTIES

ALL personnel should be familiar with how to request medical evacuation as they may need to initiate the request

Depending on the tactical situation, unit standard operating procedures, and available assets, the casualty may be evacuated by **MEDEVAC** or **CASEVAC**

TACEVAC is a term that includes both **MEDEVAC** and **CASEVAC** in the tactical environment
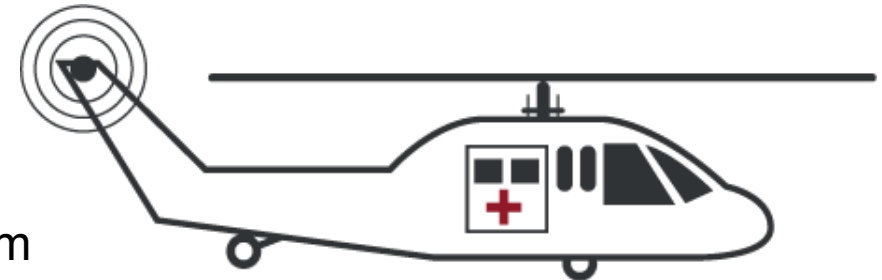
CASEVAC:

Unregulated movement of casualties aboard nonmedical aircraft, vehicles, or maritime vessels

MEDEVAC:

Transport by medical personnel of wounded, injured, or ill persons from the battlefield and/or other locations to Medical Treatment Facilities

Conducted with dedicated medical ground vehicles and aircraft, properly marked with a Red Cross and employed in accordance with the Geneva Conventions and the law of war

**MEDEVAC / MIST VIDEO
9-LINE ARMY EXAMPLE**
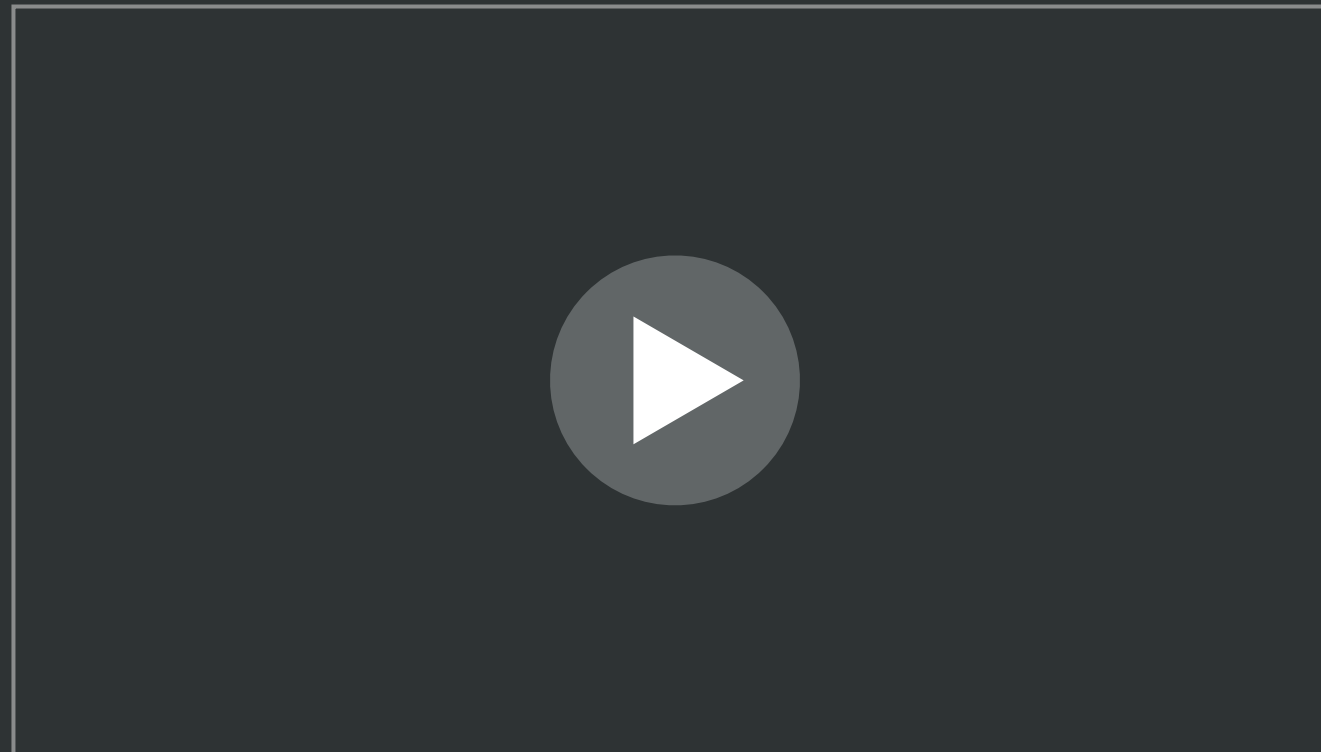
Video can be found on deployedmedicine.com

REQUESTING
EVACUATION - KEY POINTS

Every SERVICE MEMBER must be prepared to transmit a MEDEVAC request

A MEDEVAC request is **NOT** a direct medical communication with medical providers, but a means of communicating evacuation requirements so evacuation resources can be launched as needed to support evacuation of casualties

Gather **all** information needed **before** initiating transmission of the MEDEVAC request

Use **appropriate and mandated communications security and brevity codes** when transmitting a MEDEVAC request

NATO CASUALTY EVACUATION CATEGORIES

URGENT / Category A	PRIORITY / Category B	ROUTINE / Category C
WITHIN 2 HOURS	**WITHIN 4 HOURS**	**WITHIN 24 HOURS**
Significant injuries from a dismounted IED attack	Isolated, open extremity fracture with bleeding controlled	Concussion (mild traumatic brain injury)
Gunshot wound or penetrating shrapnel to chest, abdomen, or pelvis	Any casualty with a tourniquet in place	Gunshot wound to extremity - bleeding controlled with tourniquet
Any casualty with ongoing airway difficulty	Penetrating or other serious eye injury	Minor soft-tissue shrapnel injury
Any casualty with ongoing respiratory difficulty	Significant soft-tissue injury without major bleeding	closed fracture with intact distal pulses
Unconscious casualty	Extremity injury with absent distal pulses	
Casualty with known or suspected spinal injury	Burns 10-20% of Total Body Surface Area	
Casualty in shock		
Casualty with bleeding that is difficult to control		
Moderate/Severe TBI		
Burns > 20% Total Body Surface area		

Examples

CASUALTY EVACUATION CATEGORIES

North Atlantic Treaty Organization (NATO) specifies three categories for casualty evacuation:

CAT A	CAT B	CAT C
Urgent	**Priority**	**Routine**

CASUALTY EVACUATION
CATEGORIES

CAT A

Urgent
(Critical, Life-Threatening Injury)

- Significant injuries from a dismounted IED attack
- Gunshot wound or penetrating shrapnel to chest, abdomen or pelvis
- Any casualty with ongoing airway difficulty
- Any casualty with ongoing respiratory difficulty
- Unconscious casualty
- Casualty with known or suspected spinal injury
- Casualty in shock
- Casualty with bleeding that is difficult to control
- Moderate/Severe TBI
- Burns > 20% Total Body Surface Area

CASUALTY EVACUATION
CATEGORIES

CAT B

Priority
(Serious Injury)

- Isolated, open extremity fracture with bleeding controlled

- Any casualty with a tourniquet in place

- Penetrating or other serious eye injury

- Significant soft tissue injury without major bleeding

- Extremity injury with absent distal pulses

- Burns 10-20% Total Body Surface Area

CASUALTY EVACUATION CATEGORIES

CAT C

Routine
(Mild to Moderate Injury)

- Concussion (mild TBI)

- Gunshot wound to extremity – bleeding controlled without tourniquet

- Minor soft tissue shrapnel injury

- Closed fracture with intact distal pulses

- Burns < 10% Total Body Surface Area

MIST REPORT

The **MIST report** stands for:

M Mechanism of Injury
(IED, GSW, RPG, motor vehicle crash, fall, etc.)

I Type of Injury
(found and/or suspected)

S Signs
(pulse rate, blood pressure, respiratory rate)

T Treatment Given
(tourniquet, blood, pain meds, etc.)

M I S T Report

- May change as the casualty status and interventions performed change

- Conveys additional evacuation information that may be required by theater policy

- Helps better prepare receiving medical personnel/facility

SKILL STATION
Communication (skills)

✓ MEDEVAC Request

✓ MIST Report

OVER-CATEGORIZATION

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

A problem both historically **AND** in current operations

Proper classification is needed to ensure that casualties in greatest need are evacuated first and receive the care needed in an appropriate timeframe to optimize their chance for **survival**

Timing of evacuation **must** be balanced with asset availability, tactical situation, etc.

Over-categorization of casualties can result in inappropriate prioritization of evacuation assets despite constraints and risk

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TACEVAC PEARLS OF WISDOM

Soft tissue injuries are common and may look bad, but usually don't kill unless associated with uncontrolled bleeding or airway issues

Bleeding from most extremity wounds should be controllable with a TQ or hemostatic dressing and does not require urgent evacuation

Shock from uncontrolled bleeding or tension pneumothorax not relieved with needle decompression kills and requires urgent evacuation

Casualties with TBI and "red flag" signs/symptoms require urgent evacuation

Despite excellent TCCC, some casualties will not survive their wounds

SUMMARY

Importance of communication in Tactical Field Care

Techniques for requesting casualty evacuation

Information **requirements** and **format** for an evacuation request

CHECK ON LEARNING

Who should a combat medic/corpsman communicate with in the Tactical Field Care phase of care?
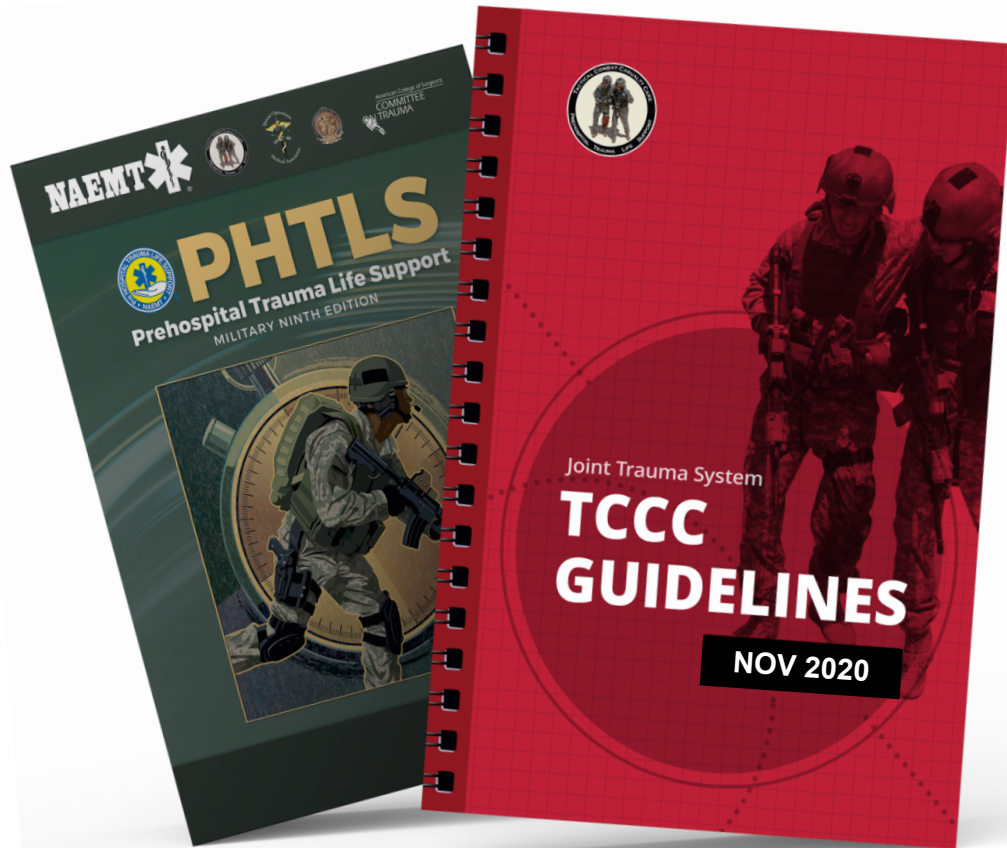
What information does the MIST report contain?

True or False? A combat casualty with 25% TBSA burns would be evacuation category A?

ANY QUESTIONS?

REFERENCES

TCCC: Guidelines
by JTS/CoTCCC

**Updated regularly – latest edition dated
5 November 2020**
These guidelines are the result of decisions made by the Committee on Tactical Combat Casualty Care as they explore evidence-based research on best practices

PHTLS: Military Edition,
by NAEMT

**Prehospital Trauma Life Support,
Military Ninth Edition**, teaches and reinforces the principles of rapidly assessing a trauma patient using an orderly approach