

Documentation in Prolonged Field Care

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

Background

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

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

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

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

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

Patient Demographics

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

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

Documentation of Prehospital Care

- **Goals:** transmit important medical information to the next level of care, permanently record information vital to service members injured in combat, and contribute to performance improvement in prehospital care.
 - **Minimum:** TCCC Card DD1380
 - The DD1380 is organized as a MIST (Mechanism, Injuries, Signs and Symptoms, Treatments) report (Appendix A).

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- o Note the time casualty is received and include time of injury (if known and different from when received) and time of all key interventions (e.g., tourniquet, blood transfusion, tranexamic acid [TXA] dosing).
- o List injuries and annotate on the diagram. Tourniquets and tourniquet times are also annotated on the diagram.
- o Vital signs, including mental status AVPU (alert or responsive to voice, pain, or unresponsive) and pain scale, should be recorded to the greatest extent possible—up to four sets of vital signs can be recorded on the TCCC card.
- o Document treatments to include external hemorrhage control, airway, breathing, fluids, medications, and other interventions on the reverse side of the TCCC card.
- **Better: PFC Flowsheet**
As a follow-on to the TCCC card, the PFC flowsheet is used to document trends over time and is the most useful tool to recognize important clinical changes in complex casualties such as decompensation, response to resuscitation, development of complications, effectiveness of medications, etc. The PFC flowsheet is one of the most effective ways to improve the level of care provided in PFC situations.
 - o When prehospital care transitions to PFC, documentation should transition from the TCCC card to the PFC flowsheet. There is no exact time for this transition to occur; however, once all of the available time blocks on the TCCC card are filled and evacuation to higher level of care is not imminent, then documentation can transition to the PFC flowsheet (Appendix B).
 - o The PFC flowsheet not only serves to document care and identify trends but also contains a checklist of interventions that may be needed through the included patient care and nursing care checklists. Such checklists can greatly aid task-saturated, fatigued Medics by providing a quick point of reference for important tasks that should be performed regularly to improve care and reduce the risk of complications to their patients.
 - o The PFC flowsheet also includes:
 - Vital signs
 - Fluid input and output
 - Medication times, route, dose
 - Physical exam findings
 - Problem list
 - Treatment plan
 - Telemedicine call script
- **Best: AAR**
 - o An AAR should be completed after patient handoff.
 - o In addition to the TCCC card and PFC flowsheet, a structured AAR is used to collect lessons learned and improve care. In cases where documentation is not able to be completed before patient handoff or was lost after handoff, the AAR can also serve as a supplement to the medical record.
 - o TCCC and PFC AARs are available online (Appendix D).
 - o TCCC or PFC AARs, along with any medical documentation not completed before patient handoff, should be completed within 24 hours of patient handoff and submitted to the Joint Trauma System (JTS) prehospital organizational email box: usarmy.jbsa.medcom-aisr.list.jts-prehospital@mail.mil.

- o The unclassified medical AAR should be accomplished in addition to unit-required classified AARs.

Telemedicine Guide

- **Goal:** Facilitate communication between prehospital provider and telemedicine consultant.
Rehearsal of telemedicine consultation between prehospital providers and remote physician consultants has shown that communication is optimized when the caller completes a telemedicine guide or script before calling the consultant and uses it during the consultation. In addition to transmitting medical information to the consultant, it is important for the caller to provide information about the care context and a summary of capabilities currently available. An image of the casualty and an image of the care environment are helpful for remote consultants to understand the operational constraints faced by the local caregiver. Capabilities that are important to convey to remote consultants may include the training level of the provider, available medications, medical supplies, monitoring, ultrasound, etc. Reading or sending a photograph of a written capabilities list will more quickly orient the consultant to the operational environment of the caller and reduce time spent asking the caller for items that are not available. If urgent teleconsultation is needed, do not delay calling to fill out a guide sheet or send e-mails. For additional details, see Teleconsultation in prolonged field care position paper.¹
 - **Minimum:** read from TCCC card.
 - **Better:** use telemedicine report incorporated in the PFC flowsheet.
 - **Best:** use the Virtual Critical Care Consultation guide (Appendix C) and send a picture of casualty, capabilities, and vital sign trends to the consultant via email or text using appropriate operational security and protections of patient privacy.

Handoff Report

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

Summarize in organized format:

- Overall condition of the patient: *stable or unstable; better, same, or worse.*
- Mechanism of injury or illness
- Injury(ies), current physical exam
- Vital signs to include trends and urine output
- Treatments (procedures, dressings, airway management, fluids, blood products, medications)
 - **Minimum:** written handoff report that follows the MIST format (e.g., TCCC Card).
 - **Better:** add the PFC flowsheet.
 - **Best:** add a dedicated handoff sheet (e.g., SBAR handoff report,² PFC handoff report³).

Electronic Documentation

Electronic documentation is the standard in hospitals and advanced field medical facilities. Devices such as the Tempus

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

Disclosures

The authors have nothing to disclose.

Author Contributions

All authors approved the final version of the manuscript.

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3. Prolonged Care MTF Handover Sheet. <https://prolongedfieldcare.org>. Accessed 28 Dec 2017.

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APPENDIX A Tactical Combat Casualty Care Card, DD 1380

TACTICAL COMBAT CASUALTY CARE (TCCC) CARD				
BATTLE ROSTER #: _____				
EVAC: ☐ Urgent ☐ Priority ☐ Routine				
NAME (Last, First): _____		LAST 4: _____		
GENDER: ☐ M ☐ F		DATE (DD-MMM-YY): _____		TIME: _____
SERVICE: _____		UNIT: _____		ALLERGIES: _____
Mechanism of Injury: (X all that apply)				
☐ Artillery ☐ Blunt ☐ Burn ☐ Fall ☐ Grenade ☐ GSW ☐ IED ☐ Landmine ☐ MVC ☐ RPG ☐ Other: _____				
Injury: (Mark injuries with an X)				
TQ: R Arm TYPE: _____ TIME: _____		TQ: L Arm TYPE: _____ TIME: _____		
TQ: R Leg TYPE: _____ TIME: _____		TQ: L Leg TYPE: _____ TIME: _____		
Signs & Symptoms: (Fill in the blank)				
	Time			
Pulse (Rate & Location)				
Blood Pressure	/	/	/	/
Respiratory Rate				
Pulse Ox % O2 Sat				
AVPU				
Pain Scale (0-10)				

DD Form 1380, JUN 2014

TCCC CARD

BATTLE ROSTER #: _____				
EVAC: ☐ Urgent ☐ Priority ☐ Routine				
Treatments: (X all that apply, and fill in the blank)				Type
C: TQ: ☐ Extremity ☐ Junctional ☐ Truncal				
Dressing: ☐ Hemostatic ☐ Pressure ☐ Other				
A: ☐ Intact ☐ NPA ☐ CRIC ☐ ET-Tube ☐ SGA				
B: ☐ O2 ☐ Needle-D ☐ Chest-Tube ☐ Chest-Seal				
C:	Name	Volume	Route	Time
Fluid				
Blood Product				
MEDS:	Name	Dose	Route	Time
Analgasic (e.g., Ketamine, Fentanyl, Morphine)				
Antibiotic (e.g., Moxifloxacin, Ertapenem)				
Other (e.g., TXA)				
OTHER: ☐ Combat-Pill-Pack ☐ Eye-Shield (☐ R ☐ L) ☐ Splint				
☐ Hypothermia-Prevention Type: _____				
NOTES:				
FIRST RESPONDER				
NAME (Last, First): _____				LAST 4: _____

DD Form 1380, JUN 2014 (Back)

TCCC CARD

[illegible]

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Prolonged Field Care Card

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

VIRTUAL CRITICAL CARE CONSULTATION (VC3) GUIDE – 2 2017 (v3.0)

To be used with Prolonged Field Care Card

1. Before calling, E-mail image of the casualty (wounds, environment, etc.), "capabilities" (back of page), & vital signs trends to dod.VC3@mail.mil
2. If call not answered: a) call next number on PACE or call back in 5 – 10 min.
3. If unable to provide information due to operational security, state so.

P: Commercial: +1 (210) 916 – VCCC (8222), DSN: (312) 429 – 8222

A: 253-968-1396

C:

E:

This is _____ I am a (job/ position) _____

My best contact info is: _____

YOUR best contact info is (Consultant's number): _____ Alternate e-mail: _____

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

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

Mechanism of Injury or known diagnosis(es) _____ that occurred in (location) _____

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

Injuries/Problems/**S**ymptoms:

Treatments:

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

Known Medication Allergies/Past medical/Surgical history is:

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

Other Consultants have recommended:

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

VITALS (current & trend as of _____): HR _____ BP _____ RR _____ SpO2 _____ EtCO2 _____ Temp _____

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

EXAM: Neuro _____ Ext/ MSK _____

Heart _____ Pulses _____

Lungs _____ Skin/ Wounds _____

Abd _____

LABS: ABG: _____ Lactate: _____ Other: _____

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

APPENDIX C *Continued*

Plans/Recommendations							
PRIORITY	SYSTEM/PROBLEM			RECOMMENDATION			
	Neuro or problem #1						
	CV or problem #2						
	Pulm or problem #3						
	GI or problem #4						
	Renal or problem #5						
	Endocrine or problem #6						
	MSK/ Wound or problem #7						
	Tubes, lines, drains or problem #8						
	Prophylaxis/prevention or prob#9						
	Other						
TO-DO/ FOLLOW-UP/TO-STOP				NOTES			
1.							
2.							
3.							
4.							
5.							
6.							
*** PAUSE POINT, for Medic/Local Caregiver to ask clarification questions/READBACK ***							
<u>Available "kit" (supplies, equipment, medications) !! IF POSSIBLE PHOTOGRAPH AND SEND VIA EMAIL BEFORE CALLING !!</u>							
IV access:	IV	Central line	IO (location)	Other: _____			
Monitor:	Propaq	Tempus	Foley	Graduated urinal	PulseOx only	Exam Only	
	Other: _____						
Commo:	Tempus i2i ID: _____		THIAB: _____	SAT# _____	Local Cell# _____		
	Web VTC Address _____						
	Other (e.g. "FaceTime, VSee, Skype, etc.): _____						
IV Fluids:	Plasma-Lyte	LR	Normal Saline	3% saline	Other: _____		
Colloids:	Hetastarch	Albumin	Other: _____				
Blood products:	Whole blood	PRBC	Plasma	FDP	Platelets	Other: _____	
Medications:	Antibiotics: name/route/dose _____						
	Morphine IV/ PO		Other opioid (name/ IV/ PO): _____				
	Fentanyl IV/ PO (pop)		Ketamine				
	Midazolam		Diazepam (IV/ PO)				
	TXA		Other(s): _____				
Airway supplies:	ETT	Cric kit	LMA	Ventilator	BVM	O2	Suction
Misc:							

APPENDIX D *Online resources*

Joint Trauma System Forms
http://www.usaisr.amedd.army.mil/10_jts.html

Joint Trauma System Clinical Practice Guidelines
<http://www.usaisr.amedd.army.mil/cpgs.html>
 Prolonged Field Care <https://prolongedfieldcare.org/>



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