TACTICAL EMERGENCY CASUALTY CARE (TECC)
CALIFORNIA QUICK REFERENCE GUIDE

HOT ZONE / DIRECT THREAT CARE (DTC) / CARE UNDER FIRE (CUF)

1. Mitigate any threat and move to a safer position.
2. Direct the casualty to *stay engaged* in operation, if appropriate.
3. Direct the casualty to *move to a safer position* and apply self-aid, if appropriate.
4. Casualty Extraction. Remove casualty from unsafe area, to include using a soft litter or SKEDCO as needed. Move casualty using a Modified Fireman's Carry, if necessary.
5. STOP *LIFE-THREATENING* EXTERNAL HEMORRHAGE, using appropriate PPE, if tactically feasible:
   - Apply effective tourniquet for hemorrhage that is anatomically amenable to tourniquet application.
6. Consider quickly placing casualty in position to protect airway, Recovery Position, if tactically feasible.

WARM ZONE / INDIRECT THREAT CARE (ITC) / TACTICAL FIELD CARE (TFC)

1. Law Enforcement casualties should have weapons made safe once the threat is neutralized or if mental status if altered.

4. BLEEDING:
   a. Assess for unrecognized hemorrhage and control all sources of bleeding. If not already done, use a tourniquet, appropriate pressure dressing.
   b. For compressible hemorrhage not amenable to tourniquet use, apply a hemostatic dressing with a pressure bandage.
   c. Reassess all tourniquets that were applied during previous phases of care. Consider exposing the injury and determining if a tourniquet is needed. If a tourniquet is not needed, use other techniques to control bleeding and remove TQ.
   d. Apply Emergency Bandage or direct pressure to the wound, if appropriate.
   e. For hemorrhage that cannot be controlled with a tourniquet, apply hemostatic Dressing.

2. AIRWAY MANAGEMENT:
   a. Unconscious patient without airway obstruction:
      - Chin lift or jaw thrust maneuver.
      - Nasopharyngeal airway.
      - Place patient in Recovery position.
   b. Patient with airway obstruction or impending airway obstruction:
      - Chin lift or jaw thrust maneuver.
      - Nasopharyngeal Airway.
      - Allow patient to assume position that best protects the airway, including sitting.
      - Place unconscious patient in Recovery position.
      - If previous measures unsuccessful:
        - Oro/Nasotracheal Intubation, per protocol.
        - Consider Supraglottic Device (King LT, CombiTube, or LMA), per protocol.
        - Needle or Surgical Cricothyroidotomy, per protocol.

3. BREATHING:
   a. All open and/or sucking chest wounds should be treated by applying an Vented Chest Seal or three-sided occlusive material to cover the defect and securing it in place. Monitor for development of a tension pneumothorax.
   b. In a casualty with progressive respiratory distress and known or suspected torso trauma, consider a tension pneumothorax and decompress with needle thoracostomy on the side of the injury with a 14-ga, 3.25 inch need/catheter unit.

5. INTRAVENOUS (IV) ACCESS:
   a. Start an 18-gauge IV, or saline lock, if indicated.
   b. If resuscitation is required and IV access is not obtainable, use intraosseous (IO) Route per protocol.

6. FLUID RESUSCITATION:
   Assess for hemorrhagic shock; altered mental status (in the absence of head injury) and weak or absent peripheral pulses are the best field indicators of shock.
   a. If not in shock:
      - No IV fluids necessary.
      - PO fluids permissible if conscious and can swallow, and long delay in evacuation.
   b. If in shock:
      - Normal Saline or Lactated Ringers, 500-mL IV bolus. Repeat bolus once after 30 minutes if still in shock.
   c. Elevate Lower Extremities.
   d. If a casualty with altered mental status due to suspected TBI has a weak or absent peripheral, resuscitate as necessary to maintain Systolic BP of 90 mmHg or a palpable radial pulse.

7. PREVENTION OF HYPOTHERMIA:
   a. Minimize patient's exposure to the elements. Keep protective gear on if feasible.
   b. Replace wet clothing with dry if possible. Place onto an insulated surface ASAP.
   c. Cover the casualty with self-heating Blanket or rescue blanket to torso, Place hypothermia prevention cap on the patient's head. Use dry blankets, poncho liners, sleeping bags, or anything that will retain heat and keep the patient dry.

8. PENETRATING EYE TRAUMA:
   If a penetrating eye injury is noted or suspected: a) perform a rapid field test of visual acuity; b) cover the eye with a rigid eye shield (NOT a pressure patch).

9. REASSESS CASUALTY AND TREAT OTHER CONDITIONS AS NECESSARY:
   a. Complete Secondary Survey checking for additional injuries or conditions. Inspect and dress known wounds that were previously deferred.
   b. Consider Splinting known/suspected fracture or Spinal Immobilization, if indicated.
   c. Use Nerve Agent Auto-Injector (ie Duo-Dote) for Nerve Agent Intoxication.
   d. Use EpiPen for Anaphylactic Reaction.

10. PROVIDE ANALGESIA AS NECESSARY:
   a. Able to continue mission:
      - Consider oral non-narcotic medication, Tylenol, 650-mg bilayer caplet, 2 caplets
   b. Unable to continue mission:
      - IV or IO access obtained:
      - Consider narcotic analgesia Morphine sulfate, or Fentanyl Citrate per protocol.
      - Consider adjunct administration of anti-emetic Ondansetron per protocol.
      - Monitor for respiratory depression. Have Naloxone available.

11. BURNS:
   a. Agressively monitor airway and respiratory status for casualties with smoke inhalation or facial burns, including oxygen or cyanide antidote treatment when significant symptoms are present.
   b. Estimate TBSA and cover burn area with dry, sterile dressings.
   c. If burns are greater than 20%, begin fluid resuscitation and consider analgesia.

12. MONITORING:
   Apply monitoring devices or diagnostic equipment if available. Obtain vital signs.

13. PREPARE CASUALTY FOR MOVEMENT:
   - Move packaged patient to site where evacuation is anticipated.
   - Monitor airway, breathing, bleeding, and reevaluate the patient for shock.

15. COMMUNICATE WITH THE PATIENT IF POSSIBLE:
   - Encourage, reassure, and explain care.

14. CARDIOPULMONARY RESUSCITATION (CPR) AND AED:
   Resuscitation in the tactical environment for victims of blast or penetrating trauma who have no pulse or respirations should only be treated when resources and conditions allow.

16. DOCUMENTATION:
   Document clinical assessments, treatments rendered, and changes in the patient's status. Forward this information with the patient to the next level of care.

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