

TACTICAL MEDIC TRAUMA GUIDE

# MARCH, TACTICAL PHASES OF CARE, AND TRAUMA TEAM HANDOFF

A pocketfriendly reference for tactical medics and TEMS providers.



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## Who This Guide Is For

This guide is intended for:

- Tactical medics integrated with law enforcement teams.
- EMS providers working in tactical or warmzone roles.
- Medically trained operators providing care beyond basic first aid.

It assumes you already have:

- Formal medical training (EMT, paramedic, nurse, physician, etc.).
- Familiarity with MARCH, tactical phases of care, and your local protocols.
- Documentation and handoff to trauma teams.

It is a quickreference, not a full textbook or replacement for protocols.

## Always Follow Your Protocols

This guide **does not** replace:

- Your medical director's protocols.
- National or regional guidelines (TECC/TCCC, local standards).
- Agency SOPs and tactical team policies.

When in doubt, follow your training, local protocols, and medical direction.

# TACTICAL PHASES AND ZONES OF CARE

Medical care happens in the context of the mission. Your treatment plan should fit the threat, mission, and resources.

## Hot / Direct Threat Zone – Care Under Fire

- Threat is active or not fully controlled.
- Priority: threat suppression, movement to cover, and communication.
- Medical care: very limited, focused on:
  - Encourage selfaid/buddyaid.
  - Rapid tourniquet application for lifethreatening extremity hemorrhage.
  - Moving casualties to relative cover when tactically feasible.

### Key Point:

- Do not perform prolonged interventions while exposed to direct threat.
- You are a force multiplier; do not become another casualty.

## Warm / Indirect Threat Zone – Tactical Field Care

- Threat is reduced/indirect but not completely absent.
- You may be inside the structure/scene, in CCPs, or in RTF/warmzone operations.
- **Priority: MARCH-driven care with tactical awareness:**
  - Hemorrhage control (tourniquets, wound packing).
  - Airway and breathing interventions within scope.
  - Rapid packaging for movement.

## Cold / NoThreat Zone – Evacuation Care

- Scene is secure or you are in secure corridors, vehicles, or aircraft.
- Priority: continued MARCH reassessment, packaging, and handoff to higher levels of care.
- More time and tools may be available (additional monitoring, meds, advanced procedures—per scope/protocol).

## Time and Communication

At every phase:

- Communicate with command: number and status of casualties, resources needed.
- Communicate with EMS: staging, ingress/egress, special access needs.
- Keep a running mental MARCH list for each casualty and update as you go.



# M.A.R.C.H. – Tactical Medical Priorities

MARCH provides a consistent, repeatable algorithm.  
Reassess after each phase/major move.



## M: Massive Hemorrhage

Identify and control life-threatening bleeding first.

### Look for:

- Obvious spurting or pulsatile hemorrhage.
- Blood pooling on ground or soaking clothing/gear.
- Partial or complete amputations.

### Actions (overview):

- Extremity bleeding → tourniquets.
- Junctional bleeding → wound packing + direct pressure (or junctional devices if available).
- Torso bleeding → rapid recognition, packaging, and expeditious evacuation.

## A/R: Airway and Respiration

### Airway:

- Responsive, speaking normally → patent airway.
- Decreased LOC, snoring/gurgling → consider manual maneuvers / adjuncts per scope.
- Catastrophic airway compromise → follow advanced airway protocol (within scope).

### Respiration:

- Look, listen, feel for breathing; inspect chest rise, work of breathing.
- Identify penetrating injuries, open chest wounds, paradoxical movement.
- Use occlusive dressings/chest seals and position for optimal breathing per protocol.

## C/H: Circulation & Hypothermia/Head

### Circulation:

- Assess pulses, skin signs, mental status; suspect shock early in the tactical environment.
- Control all external hemorrhage, consider internal hemorrhage based on mechanism.

### Hypothermia/Head:

- Aggressive hypothermia prevention from the start, even in warm climates.
- Recognize and monitor for TBI; avoid hypotension and hypoxia.



# MASSIVE HEMORRHAGE – TOURNIQUETS AND WOUND PACKING

## Tourniquets (Extremity Hemorrhage)



### Principles:

- Use commercial, CoTCCC recommended tourniquets when possible.
- Apply proximal to the wound, ideally 2–3 inches above, not over a joint.
- In Care Under Threat, “high and tight” may be appropriate for speed.

### Application steps (overview, not a how to class):

1. Place tourniquet proximal to wound.
2. Pull strap tight before turning windlass.
3. Turn windlass until bleeding stops and distal pulse is absent.
4. Secure windlass; note time.
5. Do not periodically loosen (“no tourniquet hunting”).
6. If bleeding persists, apply a second TQ proximal to the first.

## Wound Packing & Junctional Control



### For junctional bleeds (groin, axilla, neck base) and deep wounds where TQ is not possible:

1. Expose and identify source.
2. Pack with hemostatic gauze (if available) or plain gauze into the wound cavity.
3. Continue to pack firmly until cavity is full.
4. Apply strong, direct pressure over the packed wound for the recommended time per product/protocol.
5. Secure with pressure dressing if possible.

### Consider:

- Low visibility, tight spaces, and ongoing threat when deciding how long you can hold direct pressure in place vs. moving casualty.

## Reassess Every Move

Every time you move the casualty [drag, carry, load], recheck:

- Tourniquets (still tight? bleeding controlled?).
- Wound packing/dressings.
- New bleeding from previously unseen areas.





# AIRWAY & BREATHING – TACTICAL CONSIDERATIONS

## AIRWAY

### Consider:

- Level of consciousness (AVPU or similar).
- Ability to maintain airway while supine vs. sidelying.

### Interventions (within scope/protocol):

- Manual maneuvers (jaw thrust, chin lift) as allowed tactically.
- Supraglottic airway devices or other adjuncts per protocol.
- Recovery position when advanced airway not in place and tactical environment permits.

### Be mindful of:

- C-spine considerations vs. airway/oxygenation priorities.
- Environmental factors (darkness, confined spaces, noise).



## BREATHING / CHEST

### Identify:

- Penetrating chest trauma (front/back, lower neck/upper abdomen).
- Flail segments, paradoxical movement.
- Worsening respiratory distress, decreased breath sounds (if assessable), hypotension, and hypoxia.

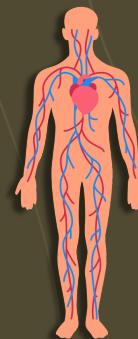
### Interventions (per protocol):

- Apply vented or appropriate chest seals to open chest wounds.
- Monitor for signs of tension physiology; notify medical control/receiving facility.
- Position casualty to optimize ventilation as allowed by injuries and tactical position.



## CIRCULATION & PREVENTING SHOCK

- Rapid recognition of shock and early evacuation are key.
- Limit scene time where internal hemorrhage is suspected (pelvis, abdomen, chest).
- Within scope, consider permissive hypotension principles and fluid guidelines per protocol and environment (if used by your system).
- Maintain aggressive hypothermia prevention (insulation from ground, blankets, heat retention).





# HEAD INJURY AND TBI IN TACTICAL SETTINGS

## TRAUMATIC BRAIN INJURY (TBI) RED FLAGS

### Look for:

- Any loss of consciousness.
- Confusion, disorientation, or amnesia for events.
- Repeated vomiting.
- Seizures.
- Unequal pupils, focal neurological deficits.
- Worsening headache or behavior.

### Priorities:

- Avoid hypoxia (maintain airway, oxygenation).
- Avoid hypotension (support circulation; minimize delays to definitive care).
- Maintain normothermia; prevent hyperthermia and hypothermia.
- Elevate head slightly if not contraindicated and if it does not compromise perfusion or tactical needs, per protocol.

## BLAST, FRAGMENTATION, AND POLYTRAUMA

### Blast/IED and fragmentation injuries:

- Expect multisystem trauma: lungs, ears, eyes, brain, extremities.
- Look for:
  - Primary blast injury (lungs, ears, GI).
  - Secondary (shrapnel, fragmentation).
  - Tertiary (throwing of body, blunt trauma).
  - Quaternary (burns, inhalation, crush).

### Key points:

- Thorough but fast head-to-toe assessment when tactically feasible.
- Anticipate occult injuries (e.g., blast lung) even when external findings seem limited.
- Early notification of receiving facility about blast mechanism.

## PAIN CONTROL & MEDS

- Follow your system's analgesia, TXA, antibiotics, and other medication protocols.
- Consider mission and evacuation timelines when choosing route and agent.
- Document drug, dose, route, time, and response for trauma team.

*(This guide intentionally avoids specifying drug names/doses—those should match your local protocols.)*



# TACTICAL MEDIC DOCUMENTATION AND HANDOFF

Good documentation and handoff significantly improve downstream care.

## WHAT TO CAPTURE

### Aim to document:

- **Mechanism:**
  - Ballistic (caliber known/unknown, estimated distance).
  - Blast (type, environment, confined vs open).
  - MVC, fall, crush, etc.
- **Initial condition:**
  - Mental status (GCS or simplified).
  - Respiratory status.
  - Obvious injuries and vital signs (if obtainable).
- **Interventions with times:**
  - Tourniquet(s): location, time applied.
  - Wound packing, hemostatic use.
  - Chest seals, airway devices, needle decompression (if within scope).
  - Medications: analgesia, TXA, antibiotics, others.
- **Response to interventions:**
  - Changes in mental status, vitals, pain.

## HANDOFF TO EMS/TRAUMA TEAM

Use a structured handoff (MIST / IMISTAMBO or similar):

Example: "This is [name/call sign], tactical medic with [agency]."

- Mechanism: GSW to left chest and right thigh at close range.
- Injuries: Penetrating chest with suspected hemothorax; thigh wound with major hemorrhage.
- Signs: Initial HR 130, SBP ~90 by palpation, RR 28, GCS 14.
- Treatment: Tourniquet to right thigh at 14:12, chest seal front left chest at 14:14, wound packing to thigh, 1g TXA at 14:20 per protocol, pain control at 14:25.
- Current status: HR 120, SBP 100 by cuff, RR 24, GCS 15, bleeding controlled.
- Concerns: Ongoing risk for chest deterioration, need for rapid imaging and blood."

### Coordinate with EMS for:

- Destination (trauma center, operating capacity).
- Air vs ground transport.
- Additional resources needed en route.



# INTEGRATING WITH THE TEAM AND SYSTEM

Tactical medicine is a team sport.

## TACTICAL TEAM INTEGRATION

- Participate in planning for operations (briefs, contingencies, routes).
  - Know team SOPs for:
    - Hot/warm/cold zones.
    - CCP locations and triggers.
    - Priority of rescue vs. threat engagement.
  - Clarify expectations:
    - When and how you move forward.
    - Who calls for evac and where.
    - How you communicate casualty count and severity.
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## EMS AND HOSPITAL INTEGRATION

- Train regularly with local EMS and trauma centers.
  - Agree on:
    - Terminology (MARCH, triage categories).
    - Preferred handoff format.
    - Local protocols (TXA, blood, RSI, decompression).
  - After real events:
    - Participate in joint debriefs.
    - Review documentation and handoff quality.
    - Identify gaps in gear, training, or communication.
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## TRAINING AND SUSTAINMENT

- Regularly refresh:
  - Tourniquet and wound packing skills.
  - Chest seals and chest assessment.
  - Airway interventions and airway decisionmaking.
  - Needle decompression or other advanced procedures (if within scope).
- Integrate medical scenarios into:
  - CQB/entries.
  - Vehicle assaults.
  - Rural/extended operations.
  - Lowlight and multicasualty scenarios.

Use realistic, stressbased training with safe tools and clear objectives.





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## Disclaimer

This guide is for general educational purposes only and is aimed at already trained tactical medical providers. It does not replace:

- Your medical director's protocols.
- National/regional guidelines or agency SOPs.
- Formal training or continuing education.

## Always:

- Follow your protocols and medical direction.
- Work within your scope of practice and authority.
- Obey applicable laws and regulations.

Use the information in this guide at your own risk.



## TACTICAL CASUALTY CARD

Name / ID (if known): \_\_\_\_\_

Date: \_\_\_\_\_

Time of injury (approx): \_\_\_\_\_

### MECHANISM

GSW

Blast

Stab

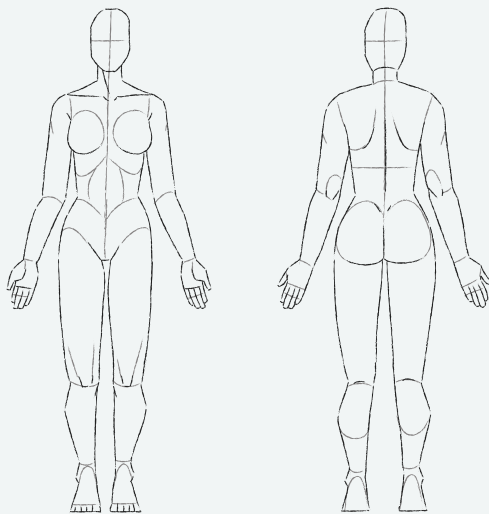
MVC

Fall

Crush

Other: \_\_\_\_\_

### INJURIES (diagram + notes):



### MARCH:

M – Massive bleeding:

TQ: Location(s) & Time(s)

A – Airway:

R – Respiration (chest seals, decompressions):

C – Circulation (IV/IO, fluids, TXA, other):

H – Hypothermia/Head (measures taken):

### Vitals / Status (if obtained):

Time: \_\_\_\_\_

HR: \_\_\_\_\_

BP: \_\_\_\_\_

RR: \_\_\_\_\_

SpO2: \_\_\_\_\_

GCS: \_\_\_\_\_

### Meds (drug / dose / route / time):

Provider initials / call sign: \_\_\_\_\_



Attach or hand this to EMS/trauma team with the casualty.

